East Sussex Better Together - DRAFT Savings/Investment **Appendix 5**

Adult Social Care, Public Health and Children's Services have been working with Eastbourne, Hailsham & Seaford Clinical Commissioning Group, Hastings and Rother Clinical Commissioning Group and East Sussex Healthcare Trust to develop an integrated Strategic Investment Plan (SIP) that will align, from 1 April 2017, total commissioning budgets of £864m (subject to ongoing due diligence).

The total 2017/18 East Sussex County Council investment within the SIP is planned at £134.996m, as set out on pages 17-18 of the budget summary at Appendix 2. The SIP planning assumptions have identified total resources of £864.6m compared to projected expenditure of £918.3m across health and social care within ESBT. There is therefore a total savings requirement of £53.7m, which includes required savings of £7.007m for Adult Social Care and £0.036m for Children's Services.

This schedule sets out the plans that are being developed, as part of the whole system health and social care redesign predicated within East Sussex Better Together, to mitigate the projected whole system financial deficit and deliver a balanced budget for 2017/18.

Due diligence continues to refine the SIP and by the 1 April 2017, there will be in place an Alliance Agreement and governance structure that will work to mitigate the financial risks of not achieving elements of the Strategic Investment Plan.

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Scheme description	**Description of investment proposal**	**Key outcomes**	**£'000**	**£'000**	**£'000**									
Healthy living and Wellbeing / Maintaining Independence. This is about preventing ill health, promoting independence and improving awareness of and access to services and activities that support healthy lifestyles.	Public Health, including: Making Every Contact Count, Smoking Cessation, Alcohol Awareness and Obesity/Physical Activity. Technology Enabled Care Services (TECS).	People will manage their own health and wellbeing; self-care options embedded and support to make lifestyle changes is integrated. Demand for health and social care services across the whole system will reduce, including demands on out of hours GP services; A&E attendance and hospital admissions.												y
	Making Every Contact Count (MECC): East Sussex Healthcare NHS Trust became one of the first healthcare providers in Kent, Surrey and Sussex to introduce MECC, a national initiative to help reduce health inequalities. o 100 staff completed Level 1 MECC training in the Hastings and Rother area, including staff from nursing, midwifery and allied health professions working in a variety of clinical settings. o The MECC programme is now being extended across the whole of ESHT with the aim of training 1000 staff members in 2016/2017. Plans are also in place to deliver MECC to Adult Social Care staff and to East Sussex Fire and Rescue Service staff who undertake home safety check visits.	MECC aims to address health inequalities in the Hastings and Rother area by using the contact that public facing staff have with individuals as an opportunity to encourage and deliver key messages to help improve their physical and emotional wellbeing. These messages could include advice on stopping smoking, eating healthily, maintaining a healthy weight, drinking alcohol within the recommended daily limits, undertaking the recommended amount of physical activity or improving mental health and wellbeing.												y
	Technology Enabled Care Services (TECS) : Technologies such as telehealth, telecare, telemedicine, telecoaching and self-care apps have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them. As part of East Sussex Better Together we have identified savings to be delivered through enhancing the delivery of TECS more rapidly and more widely across areas including falls; frailty; crisis response; medication management, to avoid hospital admissions or re-admissions.	TECS will be made more rapidly available to those most at risk of hospital admission or re-admission. This work will also have a positive impact on delayed discharges from hospital as TECS will be prescribed via hospital teams and devices will be issued from hospital bases.		**(3,770)**	**(2,688)**		+							
	Healthy Homes Scheme: A £627,000 healthy homes scheme is underway to tackle fuel poverty in six deprived areas of Hastings and Rother as part of the East Sussex Better Together programme. The 18-month pilot will focus on private homes (owner occupiers and private tenants) with poor heating, insulation and energy efficiency to reduce health risks to vulnerable children and adults. Funded by Hastings and Rother Clinical Commissioning Group (CCG) to help reduce health inequalities, the pilot has started in Braybrooke, Castle, Central St Leonards, Gensing, Old Hastings, and Bexhill Central communities.	The Healthy Homes programme will provide additional heating and insulation improvements in 148 owner-occupied and privately rented homes at an average cost of £3,250 and support the enforcement of housing standards in 76 privately rented homes												y

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Proactive Care / Crisis intervention and admission avoidance: focusses on patients with long-term conditions and illnesses.	A range of new schemes and development of existing schemes including: Falls and Fracture Liaison, Frailty Strategy, Pro-Active Care, Vulnerable Patients and Specific Conditions (incl. Ear, Nose and Throat (ENT), Musculoskeletal disorders (MSK) and Gastroenterology). Crisis intervention: procurement of an integrated service model of NHS 111 and local clinical triage and assessment service; 24/7Primary Urgent Care Service accessed via NHS 111 or via own GP; Integrated urgent and emergency care centres: enabling streaming and increased primary and social care assessment capability at front of hospital.	The investment proposals are designed to support health and independence for as long as possible. As a result, demand for health and social care services across the whole system will reduce, including demands on out of hours GP services; A&E attendance and hospital admissions. These initiatives are supported by additional NHS investment e.g. the additional workers to build community capacity, see below. Crisis intervention and admissions avoidance is aimed at ensuring the right services are in the right place at the right time to help people regain their independence and well-being quickly following a period of illness. The investment will enhance capacity and capability for proactive case finding, assessment and care planning, resulting in the ability to identify patients, clients and carers before they deteriorate. This workstream involves the management of more complex cases, ensuring the most effective use of resources and a more holistic approach to care and support.				+	+							
	Social prescribing: Southdown Housing Association's Social Prescribing service, which won a prestigious award from the Royal Society for Public Health (RSPH), supports patients with mental health challenges access non-clinical sources of community support such as benefits and legal advice. Located in GP practices at the Station Plaza Health Centre in Hastings it has been extended beyond its initial time period due to its success. Social prescribing is an area for further development across ESBT. Outcomes from the work so far: 88% of patients who used the service reported they had not been back to see their GP since working with a community wellbeing advisor, 70% of patients who use the service said it helped them achieve their goals; 60% reported a reduction in GP appointments related to their mental health.	Reductions in demand for GP appointments and services; reduced demand for mental health related support.		**(28,944)**	**(24,025)**		+							
	Building community capacity: The Strategic Investment plan reflects a range of initiatives aimed at increasing the capacity of community based services to support people in their own homes, therefore avoiding unnecessary hospital admissions and timely discharge. We have developed a phased programme of work. Phase 1 is underway and we are currently recruiting 80 additional community based workers who will undertake personal care; basic nursing; rehabilitation and reablement; basic equipment prescribing. The posts are being recruited on NHS terms and conditions in anticipation of an Accountable Care Organisation in 2018. The posts will be part of the Integrated Locality Teams. Phase 1 also includes increasing the Integrated Night Service capacity to allow for a community response service to operate 24/7 and have capacity to care for an increased community patient population.	Reduced unnecessary hospital admissions and improved hospital discharge to enable people to return home. Increased support available in the community which will reduce demand on acute and high cost residential placements. This work is supported by additional NHS investment.				+	+							

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	Phases 2 and phase 3 include the recruitment of additional community based workers and improving co-ordination of community and intermediate care beds to improve patient flows. This workstream also includes a range of initiatives to support falls self-assessment, care and prevention. These initiatives will deliver arrange of savings based on reducing hospital attendance and admissions and reductions in social care support needs.													
Accommodation & Bedded Care (hospital and community)	Initiatives to facilitate prevent admission and enable timely discharge: Integrated Equipment and Adaptations, Step-up and Step-down and Residential and Nursing Home Care, Discharge to Assess, Care Home Plus and interim beds for Discharge to Assess	Hospital and community bed placements will be more appropriate to meeting the needs of the client or patient. Lengths of stay in bedded care (hospital and community) will reduce as a result which will in turn enable increased efficiencies in hospital admission and discharge arrangements.												
	Care Home Plus: Due to the current absence of sufficient Independent Sector Care Home capacity to support hospital admission avoidance and rapid discharge (including weekends) we need to develop enhanced services within residential care homes to prevent escalation to, or direct placement into nursing care for people with no nursing care needs. This increased capacity will apply to both Step Up (admission avoidance) and Step Down (discharge). We aim to develop an additional 30 beds by March 2017; 90 beds by March 2018.					+	+							
	Community bed management: We are developing a portfolio of options for people being discharged from hospital or to avoid hospital admissions. To improve patient flows in and out of hospital, we aim to increase occupancy rates in community based beds (including community hospitals; Milton Grange; Firwood House; Non-weight bearing beds). Specific targets for the different settings are being agreed. Improved bed management will reduce the number of voids and reduce lengths of stay which will increase capacity and improve flows across the system In addition, we will utilise beds within settings such as Extra Care and secure interim bed capacity in local Hospices to support hospital discharge. For Extra Care beds, for example, we utilise this capacity for delayed transfer of care patients awaiting adaptations and equipment in their homes; re-housing; large (double–up) care home packages. This project will require agreement with District and Borough housing departments and referral and access criteria need to be agreed before this model can commence. We aim to commence this approach within the next 3 months. Overall, the combination of increased bed capacity and improved bed management will reduce the number of bed days lost across the system whilst also reducing the average community bed length of stay. At the time of writing, whole system indicators and measures are being developed to monitor the impact of this activity.			**(2,720)**	**(4,080)**	+	+							

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	Urgent Care: Extensive public engagement was undertaken from August to November this year on what matters to people when they need same day health or social care advice, care or treatment. The focus was on: o 111, the NHS telephone service o GP walk-in centres at Eastbourne and Hastings o Same day assessments and appointments, using technology (web chats and video calls) o Community pharmacists Final Urgent Care service redesign plans will be agreed in January 2017 for implementation from April 2018 and beyond, ensuring we have a range of appropriate, high quality services available 24/7 to help people get the right advice/treatment/care in the right place, first time.					+	+							
Prescribing: Working with medicine prescribers, dispensers and patients to improve the quality of prescribing and reduce medicine wastage	Prescribing Support Scheme to incentivise prescribers to change behaviour; providing additional expertise to support Prescribers in Primary Care; Drug and Alcohol services; implementation of joint formulary; integration of Community Pharmacy Medicines Use reviews in GP process and implementation of shared decision making tools.	Effective medicines management will reduce inappropriate variability in prescribing of medicines and improve safety and efficiency of repeat prescribing process. Significant savings can also be realised through reduced medicines waste.		**(5,314)**	**(7,167)**	+	+							
	Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) Medicines Optimisation Strategy 2015-2018 sets out how EHS and HR CCGs are going to optimise the use of medicines over the next three years and realise the potential efficiencies from the prescribing budget. The East Sussex Better Together (ESBT) programme affords us the opportunity to work much more collaboratively across health and social care boundaries to ensure that there is adequate support throughout the medicines pathway to secure the desired outcomes for patients as well as delivering value for money. Avoidable medicines waste in primary care is estimated to be £150m per year. This means that for our two ESBT CCGs over £1m worth of medicines waste could be avoided each year. This means that across both our CCGs over £30m investment in medicines may not be resulting in the desired outcome. 5% of hospital admissions are due to the ineffective or inappropriate use of medicines; this increases to 17% of unplanned admissions in the frail elderly.4,5 In 2014 there were over 900 non-elective acute admissions from care homes in each of our CCGs. Care home use of medicines study finds that 70% of residents were exposed to one or more medication errors every day. We have 144 care homes across our two ESBT CCGs with over 5,000 residents.													
Mental health	Provision of third sector provided peer-led support; development of crisis response; streamlined rehabilitation pathways; expanding role of third sector and primary care; Dementia Crisis Team; Dementia Shared Care wards	Demand for acute Mental Health services will reduce and lengths of stay in specialist high cost placements will also reduce. Interventions to promote self-care and wellbeing and increases in community provision will support the prevention of deterioration; reduce hospital admissions and demand for social care services.		**(1,867)**	**(4,830)**	+	+							

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Planned Care: Mainly concerned with the non-urgent care elements of healthcare. Care primarily begins in primary care with GPs either referring patients to hospital for specialist help or managing someone with a long term condition (diabetes, high blood pressure etc)	To undertake pathway redesign across a number of specialties and conditions with the aim of changing them from being reactive, crisis driven (i.e. responding only when someone gets unwell and needs urgent help) towards being a proactive system with increased emphasis on prevention, self-help self-management and providing interventions sooner and closer to an individual's home. Pathways currently being looked at are: Cardiology; Diabetes; Respiratory; Orthopaedics; Frailty; Cancer; Maternity and paediatrics	Outcomes from the Planned Care programme include: Public Health: developing programmes to help support improved lifestyles; Primary Care: Ensuring the most appropriate person makes the diagnosis in the most appropriate setting; Primary Care: Keeping people well for longer and enabling them to manage their own condition; Communication: For elective cases (e.g. referring someone for a knee replacement), ensuring effective communication between different parts of the system to ensure swift and effective treatment: Standardisation – how we ensure that whether you live in Eastbourne or Rye you consistently get the same high standard of service		**(9,862)**	**(19,995)**	+	+				+			
	Shared decision making (GP referrals): is a process in which patients, when they reach a decision crossroads in their health care, can review all the treatment options available to them and participate actively with their healthcare professional in making that decision.	National evidence shows that twenty percent of the patients who participate in shared decision making choose less invasive surgical options and more conservative treatment.				+	+				+			
	Out patient follow-up services: Many people who have received non-emergency treatment (elective care) at hospital will often be asked to return to hospital for follow up tests and care. Some routine tests and care could be offered in the community at locations which are more convenient to travel to for our patients. Some follow-up appointments could potentially be done by telephone or using computers, so some people may not even have to leave home in the future.	Reductions in demand for hospital and GP appointments.				+	+				+			
Learning Disability	Increase in people supported to live in local community settings; reduction in numbers of people in inpatient settings; consolidation of approach to market and fee levels	Strengthening the support pathway and provision to adults with a Learning Disability and challenging behaviour; improving hospital and primary care liaison; developing a crisis response service to maintain individuals in the community. This work will be undertaken as part of the national NHS Transforming Care programme which is focusing on addressing long-standing issues to ensure sustainable change that will see: more choice for people and their families, and more say in their care; providing more care in the community, with personalised support provided by multi-disciplinary health and care teams; more innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs; but for those that do need in-patient care, ensuring it is only for as long as they need it.		**(160)**	**(790)**	+/-	-							
Children's Services	Integrated delivery of Early Help services; improving offer for children with disabilities and special educational needs; improving mental health and wellbeing through the Child and Adolescent Mental Health Services (CAMHS) transformation plan	Reduction in number of children requiring services; Reduction in number of Looked After Children; Increase in children able to remain in their local communities with their families; Improved health and wellbeing		**(36)**	**(69)**	+	+			+	+			

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Enablers: Information technology; back office services; Estates; accountable care transaction costs	A systematic review of back office services and estates to ensure they are fit for purpose as we transition to an Accountable Care Organisation	Improve efficiency and cost effectiveness. Ensure the right support functions are in place to deliver accountable care.		**(1,000)**	**(3,000)**									y
			864,554	**(53,673)**	**(66,644)**									

East Sussex share of the pooled budget areas of search:		
Adult Social Care	11,114	16,000
Use of Adult Social Care Support Grant and Improved Better Care Fund to offset savings	(2,220)	(3,797)
Funding from additional Adult Social Care Precept	(1,887)	(2,039)
Children's Services	36	69
Funding transfer from Health as part of a balanced Strategic Investment Plan (SIP)	**7,043**	**10,233**

The gross budget of £864m represents the pooled in-scope budgets of the Council and the two partner CCGs. The total savings figures represent the amounts required for the partners to achieve pooled financial balance in 2017/18 and 2018/19 respectively. The County Council's share of the required savings is as shown above.