Summary of ESBT services and improvements in 2017/18

Introduction

This paper focuses on ESBT Alliance activity between April 2017 and March 2018, building on ESBT achievements in previous years. The ESBT 150 week programme itself formally concluded in June 2017, and a summary closure report detailing the progress made by the programme between August 2014 and June 2017 can be found on the ESBT website[1]. Following June 2017 much of the ESBT programme activity became core business, and doing things differently and better to make improvements to our system and maintain improved quality standards, for example in A&E and delayed transfers of care, has become 'business as usual'.

This report provides a snapshot of some new areas of work taken forward in 2017/18 and highlights some illustrative examples of improved outcomes, grouped under the following headings:

1. Improving health and embedding prevention
2. Healthy Hastings and Rother
3. Integrated care services
4. Mental Health
5. Enablers - ESBT Workforce and IMT/Digital

1 Improving health and embedding prevention

The Personal and Community resilience workstream co-ordinates activity across partners to create a step change in the way in which prevention is embedded across the whole system. The programme includes a range of settings based activity alongside targeted service improvement, the highlights of which are set out below. The programme is recognised in the LGA annual public health report – 'Public Health Transformation Five Years On' - as an example of public health transformation in local government [2]

1.1 Health Improvement – targeted service improvement

NHS Health Check

The NHS Health Check provides everyone aged 40-74 (without a relevant pre-existing condition) an assessment of their future risk of Cardiovascular Disease (CVD), and personalised information on the steps they can take to address their risk, once every 5 years. In addition to the core programme of NHS Health Checks offered by GP surgeries an extended NHS Health Check workplace programme has encouraged health and social care workers to take up their offer of an NHS Health Check by offering it at work, contributing to improving the health and wellbeing of this key workforce.

Through the workplace programme in 2017/18 nearly 2000 (n=1996) staff had their Health Check at work – around 1/3 of all eligible staff across ESHT, SPFT and ESCC- a much higher uptake rate than similar pilots undertaken by NHS England which had an average uptake of 11%

[1] http://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/150-weeks-of-esbt/

[2] https://www.local.gov.uk/sites/default/files/documents/22.14%20Public%20health%205%20years%20on_Web.pdf

One You East Sussex

August 2017 saw the launch of our new integrated lifestyle service, One You East Sussex- a one-stop shop offering evidence based personalised support to enable people to make changes to their lifestyle to improve their health. The service has a particular focus on the high proportion of people (over a quarter of adults) who have three or more lifestyle related risk factors for diseases like diabetes, heart disease and cancer, and is developing a differentiated support offer based on individual need using Patient Activation Measure (PAM) to identify people who are least likely to be able to make changes on their own, and an enhanced self- care offer for those who could make changes on their own. A promotional video highlighting the use of the national One You branding in East Sussex integrated lifestyle service as an example of good practice will be launched at the national Public Health England conference in September.

The new integrated service model resulted in:

- High levels of referrals to the service -almost 4000 people since the new service commenced
- Higher rates of service users from target communities who are least likely to make changes on their own e.g. 49% of service users reside in areas with Index of Multiple Deprivation (IMD) scores in either quintile 1 or 2
- An increase in the proportion of people achieving their goals e.g. almost two fifths (38%) of people needing weight management support achieved at least 5% weight loss (compared with less than one fifth (18%) previously, and 2/3rds (65%) achieved at least 3% weight loss compared with 2/5ths (40%) previously. The service has also seen an increase in men setting weight loss goals from under 1/^{5th} previously to almost 2/5ths of service users. And where people accessed the service for stop smoking support quit rates increased from 55% to 59% quitting successfully.

1.2 Health Improvement - settings transformation programmes

Transformation projects have been established to create a step change in the way that the places where children spend their time, support and promote health and wellbeing.

Early Years

One in five children in East Sussex are overweight or obese by the time they start primary school, rising to one in three by the age of 10-11 years, making them more likely to develop health-related problems earlier in life.

The nursery transformation project was set up to create a shift in the way in which nurseries support parents and the children in their care to lead healthy lives Over the two years of the programme the vast majority of nurseries in the ESBT area - more than 140 nurseries – have participated (over 200 countywide. Nurseries were supported by a dedicated Healthy Active Little Ones (HALO) team to audit themselves against best practice guidelines for healthy eating and physical activity, develop improvement plans and use a small grant to make changes to their practice such as providing portable and fixed physical activity equipment, cookery and gardening resources, parental engagement initiatives, and practitioner training.

The project has reached over 5,600 nursery children across East Sussex and the activities continue to be specifically recognised within nursery Ofsted inspections. A video also

highlights the impact that delivery of training to improve physical activity provision has had for children, families and staff at Park Road under Fives Nursery in St Leonards-on-Sea.

Schools
All state-funded education settings in East Sussex were invited to participate in a whole-school health improvement transformation project. Across the county 188 out of 195 schools (96%) participated in the programme. To date 181 schools (96% of those participating) have completed school health profiles, whole-school health improvement reviews and action plans, helping to make health and wellbeing part of every aspect of school life; from improving the school environment to changes to lesson planning and staff training.

Schools have supported pupils to set up and run healthy tuck shops, set up 'Daily Mile' initiatives, established parent-led gardening clubs, improved playground equipment, redesigned their lunchtime menu, run sessions in food growing and cooking and introduced techniques to improve children's emotional wellbeing. The focus on whole-school approaches means that up to 53,302 children and young people in East Sussex schools will have been reached through the project.

Healthcare settings
Work has been undertaken with East Sussex Healthcare Trust to transform the Trust so that health improvement is embedded in all the work that the trust undertakes. This includes:

- 2243 healthcare staff trained to use Making Every Contact Count(MECC) approaches to provide brief advice and refer into lifestyle support services, where required
- The Trust has audited itself and developing improvement plans against all NICE public health guidance to ensure best practice is embedded

General Practice health improvement transformation programme- 34 ESBT practices have developed and are delivering their plans to embed health improvement into the work of the practices. Examples of activity include:

- Addressing social isolation using Patient Participation Group members as 'community connectors'
- Training practice staff in Making Every Contact Count
- Working with Patient Participation Groups (PPGs) to increase their health promotion role in the practice

Pharmacy health improvement transformation programme

- 96 pharmacies (across county) registered as Healthy Living Pharmacy Level 1
- 24 pharmacies(across county) signed up to offer Health Living Pharmacy Level 2

Community settings

Active East Sussex
A mass participation physical activity intervention – Beat the Street – was delivered across East Sussex. The initiative is a fun, free game which connects individuals with their local environment and supports long term behaviour change through creating a social norm around being active. Over 42,000 people in East Sussex took part in the game in 2017; walking, cycling or running a combined total of 231,090 miles. Based on participants who completed the initial and follow-up questionnaires, the proportion of:

- children reporting the lowest levels of activity (60 minutes or more of at least moderate intensity activity on 0-1 days in the past week) decreased from 22% before Beat the Street to just 5% immediately after;
- children agreeing that being active is 'not at all interesting' decreased from 13% to just 7%;
- adults living in areas that are among the 20% most deprived nationally (IMD 2015) who reported meeting national physical activity guidelines (150 minutes of at least moderate intensity physical activity) increased from 30% before Beat the Street to 52% immediately after;
- adults who reported walking on 5-7 days in the past week rose from 58% before Beat the Street to 77% immediately after.

Social Prescribing system development

Through the community resilience programme a range of activity has been undertaken to enable people to engage in community led activity to improve their health and reduce demand for health and care services. This includes:

- Developing a new Locality Link Worker role to better link health and social care teams and communities
- Establishment of 6 Locality Networks to bring together health, social care, other statutory sector, voluntary and community and independent sector staff to identify shared priorities and work collaboratively to address these. In 2017/18 4 network meetings were held in each of the 6 ESBT localities, with themes including intergenerational working; food outdoor spaces and activities; engaging, involving and working together across our communities; volunteering; and tackling isolation.
- Appointment to a post in ESCC procurement to develop an East Sussex approach to the use of the Social Value Act to support delivery of community resilience programme aspirations e.g. by securing free of charge technical support, staff volunteering, use of organisational resources, small grants etc. through the Tendering process building on learning from pilots for East Sussex Highways contract and Integrated lifestyle Service
- Development of a 'pipeline' approach to increase the amount of external funding secured to address shared priorities through better collaboration
- Piloted a small grants programme to stimulate grass roots activity
- Piloting hub and spoke community centre approach in Hastings and Rother
- Supporting the development of new Good Neighbour schemes.

2 Healthy Hastings and Rother

Part of ESBT and launched in 2014, Healthy Hastings and Rother aims to reduce health inequalities by improving health and wellbeing of people in in Hastings' and Rother's most disadvantaged communities. It is led by NHS Hastings and Rother Clinical Commissioning Group, and supported by a range of partners, including East Sussex County Council, Hastings Borough Council, Rother District Council, East Sussex Healthcare NHS Trust and the voluntary and community sector.

In 2017/18 the following projects have supported the achievement of better outcomes and access to services for local people:

- **Improving awareness, early diagnosis and treatment of cancer** by supporting GP practices to undertake cancer action plans resulting in 13,000 patients (who had not previously participated in national cancer screening programmes) being engaged by their GP practice and encouraged to participate. 24 volunteers have been recruited to raise awareness of the signs and symptoms of cancer in their communities, leading to 2277 brief interventions and 77% of people reporting increased awareness and understanding of cancer.
- **Enhancing our community pharmacy programme** with 98% of pharmacies achieving Healthy Living Pharmacy Level One qualification.
- **Establishing Health and Wellbeing Community Hubs in North East Hastings, North West Hastings, Central St Leonards, Central Bexhill and Sidley**. Following extensive partnership work in these communities the hubs will help local people and communities to improve and manage their health and wellbeing via access to information, signposting and support in one convenient place.
- **Launching a Safe Space for vulnerable young people** in the Hastings night-time economy where they can access support, advice and first aid.
- **Launching and out of hours Staying Well Space for adults** experiencing mental health problems to de-escalate issues, prevent crisis and reduce hospital attendance.
- **The Primary Care Learning Disability Health Liaison Project** has validated 21 out of 23 Hastings and Rother GP Learning disability registers, increasing the number of people on registers by 213 (23%). This has enabled 97 more annual health checks to be completed in HR than in 2016/17 to ensure the unmet health needs of people with learning disabilities can be identified, for example increasing uptake of cancer screening services and physical health outcomes. Additional information is also added to the Summary Care Record so that vital information can be seen in other healthcare settings, alongside awareness training, 'This is Me' Care Passports and easy read appointment letters and pre-healthcheck questionnaires.
- **Launching a co-investment programme with HBC, Optivo and Orbit housing associations** which includes support for young people and their families, adults on low incomes and/or living with long term conditions; as well as Making Every Contact Count and Leadership training for staff.
- **Continuing to deliver community connector social prescribing service** which has led to a post-intervention decrease in GP appointments by 79%.

In addition, we are proud to report that a number of further projects have received national recognition in 2017/18, including:

- ESCC's project to support patients with long term conditions / dementia was shortlisted for the National Dementia Care Awards
- ESCC's Postive Parenting Programme (Triple P) was highly commended for its commitment to developing and implementing a sustainable programme that reduces health inequalities at the New NHS Alliance's awards.
- SPFT's i-Rock project won the 'Partnership Working and Co-production' award at the National Children and Young People's Mental Health Awards
- Seaview won a Kings Fund and GlaxoSmithKline award for its impact on addressing health inequalities amongst homeless people.

3 Integrated care services

Building on ESBT's vision of joined up proactive community based care, the following progress has been made in 2017/18 on our community based integrated care services and initiatives:

Health and Social Care Connect (HSCC)
Contacts and referrals to HSCC continue to increase. In 2017/18 HSCC received 130,411 contacts and referrals, an increase of 9% compared to 2016/17, all of which was managed within existing resources.

Frailty Practitioner Service
Since the service launched in April 2016 this has supported over 850 patients using Comprehensive Geriatric Assessment framework, of which over 250 have also received the PEACE (Advance Care Planning) intervention giving the following outcomes:

- 85% of patients are satisfied the service supports a better quality of life and 97% are satisfied they are involved as partners in their care
- Reductions of 81% in hospital admissions and 95% in bed days achieved for the first 81 patients receiving the PEACE intervention
- 83% of relatives preferred that PEACE Planning took place in a nursing home and not in hospital
- An estimated net position for PEACE Planning (not all patients) suggests a saving of £3,765 per patient.

Integrated Locality Teams (ILTs)
ILTs continue to develop and build relationships with other practitioners. The Hastings ILT are piloting an ILT led multidisciplinary team meeting in collaboration with primary care and mental health colleagues. This will allow timely multi-professional discussion and planning for individuals with complex care needs. It will also allow the allocation of a care co-ordinator to oversee the agreed plan.

Crisis Response Team
The crisis response team has met its targets for admissions avoided and has now expanded its role to support the discharge to assess agenda. The team has been boosted by Integrated Support Workers (ISWs) who are able to provide immediate homecare support for those who would otherwise be unable to be discharged from hospital, which has had a positive impact on ESHT delayed transfers of care.

Proactive Care Practitioners (PCPs)
PCPs are playing a key role in the new diabetes integrated care pathway. Newly diagnosed diabetics will be assessed using the Patient Activation Measure (PAM). For those who score low on activation the PCPs will work with them on a one to one basis to help them learn about their condition and help them adopt appropriate self-care behaviours.

Six Locality Planning and Delivery Groups (LPDGs) were also launched in 2017/18 across each of our six ESBT localities (Eastbourne, Hailsham and Polegate, Seaford, Hastings and St Leonards, Bexhill and Rural Rother) as a means to enable both planning and oversight of operational delivery of services at a local level. LPDGs have been established to determine local priorities, identify the best use of resources to make the greatest impact and/or the most effective impact on services for local people.

The groups will have a key role in improving access to services and achieving better outcomes for local people by beginning to understand and influence the quality and quantity

of care services within a locality, as the core building block of our ESBT integrated care model. The key functions of the group are summarised below:

- Foster closer partnerships between providers and multi-professional teams to promote the co-ordination and integration of services locally;
- Determine local priorities focussing use of resources where it makes biggest impact;
- Identify opportunities to improve access and achieve more effective outcomes for patients;
- Influence and inform the planning and delivery of local services;
- Ensure the effective adoption and implementation of ESBT SIP clinical strategies and agreed redesign of care pathways within the locality;
- Oversee the quality and quantity of care services within a locality to deliver improved outcomes for the local community.

Membership of each LPDG is varied and is drawn from GPs, community health and social care, mental health, children's services, community pharmacy, the voluntary and independent sector, and District and Borough and housing partners. By bringing together the right people in the room, including key providers and influencers of health and care in the locality, we can begin to unpick and agree what we can do to ensure our integrated health and care system works locally and what we might need to put in place to allow that to happen.

Whilst membership of the LPDGs includes representatives from the voluntary and independent sector, the need for strong links with the newly established 'Locality Networks', which have been established as a way to bring together local people, organisations and communities to share knowledge, insight and experience about their locality and the support provided within it, was recognised from inception. The new Locality Link Worker role (LLWs) that came out of the ESBT Personal Community Resilience workstream will act as the key conduit between the two forums.

The next steps in 2018/19 will be to develop a 'Strategy on a Page' and roadmap which will outline the key objectives and priorities for each locality, in the context of and aligned with our wider ESBT system-wide plans and objectives for 2018/19.

4. Mental Health

Building on the achievement by both CCGs of the target rate for diagnosing people with dementia (greater than 68% in April 2018), so that more people can be identified and given appropriate support, the CCGs have invested in enhanced and expanded post-diagnostic services, which have now been commissioned. These will provide specialist community development workers aligned to GP Practices, to provide a wide-range of 'universal' social care and support services to people with dementia and their carers.

We have sustained and expanded our investment in Psychological Therapies services and trainees, with high conversion rates to local recruitment on becoming qualified. This has resulted in being able to back-fill experienced staff who have undertaken Long Term Conditions training, to be released to increase treatment provision to those with co-morbidities, which evidence suggests reduces avoidable hospital admissions.

At the same time we are able to maintain our target trajectories for improving access to psychological therapies by delivering to 19.5% of population prevalence in 2018/19 with a run-rate of greater than 20% at year-end.
Investment levels in third-sector provision of a wide-range of social care and support services for people with ongoing mental health problems has been sustained, despite the

challenging financial climate. The following services were commissioned in 2017/18:

- a crisis café;
- growth in individual placement (employment) support;
- in association with SPFT (who provide clinical in-reach and psychological therapies), an innovative new service for people with personality disorders, who are currently high users of not only specialist mental health but also primary and acute / general hospital services, including A&E, and;
- two urgent care lounges, offering a calm place to wait for assessment

In order to address the significant health inequalities experienced by those with serious mental illness, we are investing in a new primary care service to deliver a full range of physical health checks to people with Serious Mental Illness (SMI) on QOF Registers, as well as working with voluntary organisations to support onward referrals and the subsequent take-up of smoking cessation and other health and wellbeing programmes. We anticipate these checks being completed for approximately 20% of those on SMI QOF Registers in 2018/19, with a run-rate at year-end sufficient to achieve the target rate of 50% for primary care-based checks in 2019/20

These initiatives will enable us to fulfil our obligations to deliver the Mental Health Investment Standard in 2018/19, whilst at the same time making significant contributions as part of our STP, to the financial sustainability of our mental health services across the spectrum of care.

5. Enablers – ESBT workforce and IMT/Digital

5.1 ESBT Workforce

Building on the ESBT Workforce Strategy, initiated under the ESBT 150 week programme, a number of programmes of work have been taken forward in 2017/18 as part of wider work to seek whole systems solutions to our local workforce recruitment and retention issues. Work streams cover GP recruitment and retention and innovative working; practice nurse and other practice staff recruitment and development; different ways of working across GP clusters and locality footprints and exploring new roles and ways of working. The following highlights work in 2017/18:

ESBT Community Education Provider Network (CEPN)

- **GP bursary scheme**. The scheme (funded by the CCG through its GP Forward View (GPFV) initiatives programme) made £5,000 available to newly recruited GPs to enable them to continue with their career development and encourage them to remain working in East Sussex.
- **Implementation of Care Navigation pilot within GP practices** commenced with an introductory stakeholder conference in December 2017 followed by training workshops in Spring 2018. The first wave of care navigation has now been launched (May 2018) with 18 practices participating in the pilot, and 283 staff have been trained to date in care navigation. A second phase is being planned for Autumn 2018 for the remaining interested practices.
- **GP Fellowship scheme** introduced in 2017 and funded as a GP Forward View (GPFV) initiative by the CCG, this is a scheme which offers a portfolio approach to a two-year post where GPs work four sessions a week in primary care, four sessions a week in a specialty and undertake a postgraduate certificate in Health and Wellbeing at Canterbury Christ Church University. In 2017, the CEPN recruited three fellows to the scheme and feedback indicates that the a place on the scheme has been a major factor on their decision to remain working as a GP in East Sussex.
- **Collating consistent workforce data to inform primary care workforce planning** The CCGs committed to addressing the gap in primary care workforce planning and

information analysis. A post has since been funded for 0.6 wte (22.5 hours pw) for 2 years and appointed to in May 2018. This role will be key in finalising the workforce planning aspect of the CCGs Primary Care Strategy to be published in 2018.

- **ESBT participation in the Sussex and East Surrey STP International GP recruitment bid to NHS England** - ESBT agreed to join the STP led funding request to be part of the NHSE recruitment campaign for EU GPs. It is anticipated we will welcome the first candidate pool for an orientation weekend in East Sussex / Brighton & Hove in Mid-September, with the first cohort being available to start in January 2019. We now have 8 practices who have committed to become accredited GP clinical supervisors who will be attending a training day on 28th June at University of Brighton. The project team included representation from the Deanery, CEPN and EHS, H&R and HWLH CCGs.
- **Improve the percentage of practices supporting pre-registration student nurses.** Working with practice managers to increase the number of pre-registration places available, 28 of 47 practices have now been audited as ready to host pre-registration student nurses.
- **Preceptorship to all newly qualified practice staff** the preceptorship framework has supported three newly qualified nurses in Eastbourne, Hailsham and Seaford CCG area**.**
- **Workflow redirection training** Practices across the ESBT footprint have taken part in workflow redirection training to reduce unnecessary admin for GPs. Training was offered in two parts and several practices took part.
- **Local careers events** The CEPN continues to participate in local career events given their value in attracting and retaining GPs and other health professionals in the area.

ESBT Organisational Development Group

- **ESBT OD Practitioner programme and masterclasses –** working in partnership with Sussex Partnership Foundation NHS Trust (SPFT), funding was secured from Kent Surrey and Sussex Leadership Academy (as part of the 'in place' leadership development bids held in October 2017) to design and deliver an OD practitioner programme across our ESBT system. 19 attended and completed the taught programme in May 2018 which was delivered alongside a series of six innovative and unique masterclasses. ESBT now has a cohort of 19 trained internal OD practitioners that are able to use their OD knowledge and skills to support our system transformation.

ESBT Strategic Workforce Group

- **Workforce Planning project -** ESBT Strategic Workforce Group has successfully led on a bid to the STP Local Workforce Action Board (LWAB) to fund an STP wide workforce planning project. The project is due to commence in July 2018 and will develop a workforce planning network across the STP, as well as setting out the arrangements and resources needed to collate and analyse workforce information to enable meaningful workforce modelling to be undertaken across the STP. It is expected that this role will inform ESBT place-based workforce plans going forward, including the introduction of new and/or extended roles to address the current workforce supply/skills gap.

5.2 ESBT IMT and Digital

Our ESBT Digital Strategy 2017-2021 was endorsed by the ESBT Alliance Governing Board in November 2017 to further develop our IT digital and back office systems to support the delivery of integrated care.

The ESBT Digital Team, working in close collaboration with organisational digital teams, has completed a number of projects to enhance and enable closer integrated working across health and social care. These include:

- Integrated Care Record development has been progressed dung 2017/18, and is currently preparing for delivery of Summary Care Record data into Acute, Community and Social Care service settings directly accessible through health and care professionals' day to day systems, with further developments planned in 18/19;
- Wifi rollout across all main NHS and Local Authority sites in East Sussex, including GP practices so that staff from any organisation can access their own network directly;
- Localised print solutions for joint teams so they can share devices;
- Federating email diaries so that staff in different organisations can see each other's calendars;
- Continued roll out of Skype across all ESBT organisations
- Joint service desk arrangements so users in integrated teams only need ring their usual IT service desk.