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| **Report to:** | **East Sussex Better Together (ESBT) Strategic Commissioning Board** |
| **Date of meeting:** | **12 October 2018** |
| **By:** | **Director of Adult Social Care and Health<br>East Sussex County Council (ESCC)**<br><br>**Managing Director<br>NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Commissioning Group (HR CCG)** |
| **Title:** | **ESBT Alliance Outcomes Framework: the experience of local people** |
| **Purpose:** | **To provide the ESBT Strategic Commissioning Board with an update on progress with monitoring system-wide performance against the outcomes in the experience of local people domain.** |

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***RECOMMENDATIONS***

**The Board is recommended to:**

- **Note the progress made with identifying and securing data to further understand our performance on a system-wide basis.**
- **Note the highlights shown here as examples of how we can start to measure outcomes in the experience of local people domain on a system-wide and population basis, and the actions being taken with a view to improving outcomes.**

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## 1. Background

The ESBT Alliance Outcomes Framework is a set of shared system-wide priority outcomes the Alliance has agreed to work towards and further test and develop. The framework for 2018/19 has ten strategic objectives and eighteen desired outcomes set out within four domains: population health and wellbeing; experience of local people; transforming services for sustainability and quality care and support:


1.1 A one page summary of the outcomes framework and the latest performance reports can

be found on the ESBT website[1]. Ultimately it is envisaged that the outcomes framework will:

- Enable us to understand if our ESBT Alliance arrangement is working effectively to deliver improvements to population health and wellbeing, experience, quality, and sustainability.

- Enable commissioners, providers and staff working in the system to recognise and use the same outcomes framework to guide their work with patients, clients and carers, and see how their activity or part of the care pathway contributes to delivering the outcomes that are meaningful for local people.

- Complement the way the ESBT Alliance uses our collective business intelligence to understand the performance of the health and care system as a whole.

1.2 The last report to the Strategic Commissioning Board on 6 June 2018 focused on the quality care and support domain. This report focuses on the experience of local people domain. It should be noted that we are predominantly using data that is currently available through our ESBT organisations, although we are seeking to take a whole population focus wherever possible. To produce this focused report, we have brought together current performance information collected by the Alliance organisations, and included within the outcomes framework (the data source is noted in the report), with additional quantitative and qualitative information. The report looks at performance in 2017/18 compared to 2016/17 and 2015/16.

## 2. The experience of local people

### 2.1 Desired outcomes

2.1.1 The strategic objectives, outcomes, indicators and measures within this domain can be seen at Appendix 1. The domain consists of six desired outcomes:

- Health and care services talk to each other so that people receive seamless services
- Jargon free health and care information can be found in a range of locations and formats
- People feel respected and able to make informed choices about services
- People have choice and control over services and how they are delivered
- People are as independent as possible
- People are supported to feel safe.

The paragraphs below describe the key indicators and performance measures under each outcome that have been chosen to demonstrate progress and trends over the last three years.

### 2.2 Desired outcome: health and care services talk to each other so that people receive seamless services

2.2.1 A key indicator of the experience of local people is the proportion of people and carers reporting they have only had to tell their story once. In the outcomes framework this is measured by the two questions asked in our local adult social care (ASC) 'listening to you' survey:

*Figure 1: Percentage of people (ASC clients) who contact us about their support, who have not had to keep repeating their story*

[1] https://news.eastsussex.gov.uk/east-sussex-better-together/stakeholders/outcomes-framework/

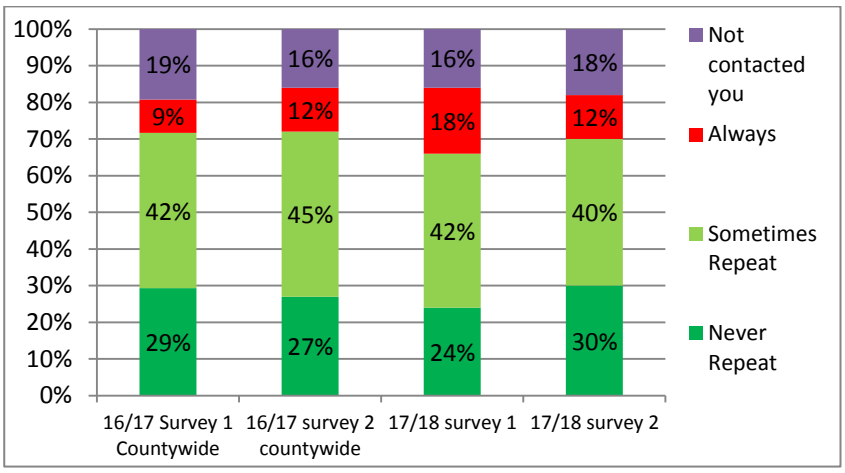
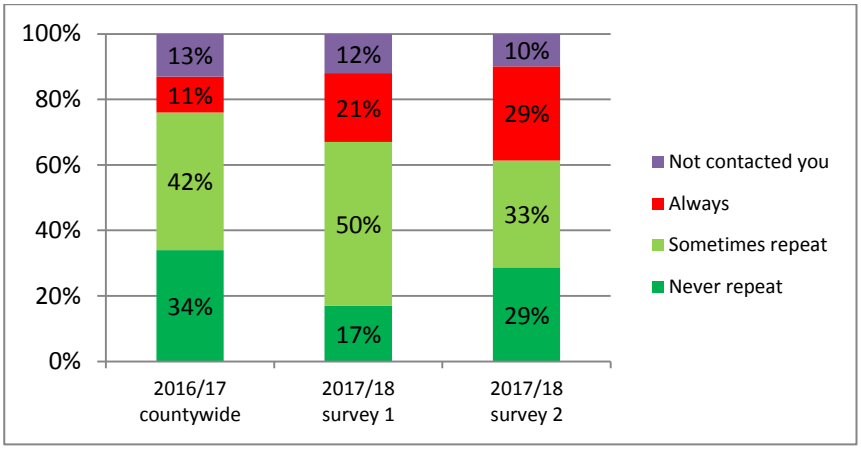



*Figure 2: Percentage of carers who contact us about support, who have not had to keep repeating their story*




Performance against these measures is mixed however there are a number of services in place and developments under way that are designed to create more seamless services. Some examples are highlighted in sections 2.2.3 – 2.2.6 below.

2.2.2 Results from the latest **East Sussex Healthcare Trust (ESHT) inpatient survey** relating to waiting lists and planned admissions give a score of 8.9 out of 10 for transitions between services. This means that the majority of people referred to hospital felt that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them.

2.2.3 **Health and Social Care Connect (HSCC)** offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals. This means adults in need of care and support, and their carers, receive faster access to the services they need at home or closer to home. HSCC was set up by bringing together three separate services (health referrals, social care assessments and a public adult social care helpline) into a single team able to deal with any health or social care enquiry from any source.

2.2.4 Working with Surrey and East Sussex Sustainability and Transformation Partnership (STP), ESBT is implementing an **Integrated Care Record (ICR)** to improve the way we provide care, to prevent people using our services having to relay the same information many times, and to improve information governance. A vital piece of this work is making data held in primary care systems available in the ICR. The central principle of the ICR is that data belonging to someone using our services is properly managed in accordance with the law and sound information governance principles, and is available to appropriate practitioners when they are providing direct

care. We will begin the ICR pilot with a small number of practitioners in Adult Social Care at ESCC and acute care in ESHT in the autumn.

2.2.5 We are working to make mental health crisis plans available across the system to ensure that colleagues in adult social care and in our acute settings have access to crisis plans. Following conversations at our Locality Planning and Delivery Groups access to Sussex Partnership NHS Foundation Trust (SPFT) care notes has been made available to colleagues in our social work teams.

2.2.6 Work to ensure **children and families** receive seamless services includes:

- Health Visitors and midwives work together to co-ordinate approaches to their work on attachment and support to new parents; this includes co-ordinating the time of statutory visits so that they do not clash and developing information sharing protocols to enable timely sharing of relevant information.

- The Inclusion, Special Educational Needs and Disability service, Public Health and Community Paediatrics have worked together to review a number of cases involving health, social care and education with a view to identify action points to improve communications and pathways for vulnerable young children and to make some aspirational recommendations for the future.

- We are working to amalgamate Single Point of Advice (SPOA) front door and Child and Adolescent Mental Health Services (CAMHS) to reduce delay for children and young people and ensure a seamless service (SPOA provides a front door for all referrals for children how need either early help or social care support).

## 2.3 Desired outcome: jargon free health and care information can be found in a range of locations and formats

2.3.1 A key indicator of the experience of local people is the proportion of people and carers reporting they find it easy to access and use information about services. This is measured by the question in the national adult social care survey[2]: "In the past year, have you generally found it easy or difficult to find information and advice about support, services or benefits?"

*Figure 3: Percentage of people who find it easy to find information and advice about support, services or benefits.*

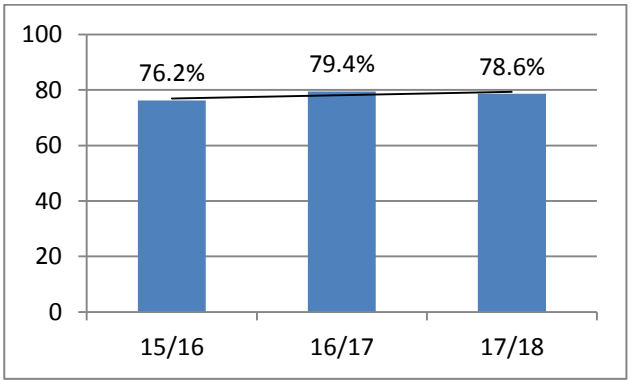
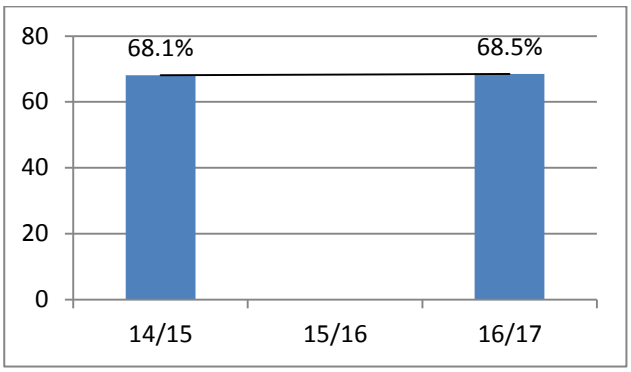



*Figure 4: Percentage of carers who find it easy to find information and advice about support, services or benefits (Note: surveys are carried out every two years)*

[2] Adult Social Care Outcomes Framework (ASOCF): https://digital.nhs.uk/data-and-information/publications/ci-hub/social-care




The percentage of people using adult social care services who responded *very* or *fairly easy to find* has shown an overall slight upward trend from 2015/16 and has been above the South East and national averages. The percentage of carers who responded *very* or *fairly easy to find* has also increased slightly from and was above the South East and national averages.

2.3.2 Ensuring jargon free health and care information can be found in a range of locations and formats remains a key priority for the Alliance partners and there is a broad range of activity across the system designed to achieve this. Examples include:

- **Health and Social Care Connect (HSCC)** our single point of access for adult health and social care enquiries, assessments, services and referrals (see 2.2.2).

- We continue to involve people as we draft and design health and care information to make sure it is easy to understand and jargon free. We use the **Adult Social Care People Bank, Local Voices Network and Patient Participation Groups** (PPGs) to sense check literature, wording and documents. Specific examples include self-care resources; zero tolerance to violence poster; and the extended access GP survey.

- The '**stay positive' social marketing aspect** of Children's Services parenting team focuses on destigmatising parenting support and encouraging earlier access to information and or services either directly from the service or elsewhere, encouraging self-sufficiency and self-regulation. As part of this, the team has recently launched its updated website which has been informed by parents and other stakeholders[3].

- Young people from the Youth Cabinet and Download mental health participation group in East Sussex produced a Top Ten Tips booklet and poster **advising schools how to support pupils' mental health and wellbeing**. More detailed guidance has also been produce to promote a whole school approach to addressing mental health and emotional wellbeing.

- Ongoing work with a range of stakeholders to improve knowledge of and **access to community mental health services**, including the current redevelopment of the East Sussex Mental Health Directory of Community Support[4] and inclusion of services on the GP DXS[5] system, East Sussex 1Space[6], ESCIS[7] and the support with Confidence Directory[8].

[3] openforparents.org.uk/
[4] eastsussex.gov.uk/media/9677/mental-health-directory-of-community-support-2017.pdf
[5] dxs-systems.co.uk/Products.html
[6] eastsussex1space.co.uk
[7] escis.org.uk/
[8] apps.eastsussex.gov.uk/socialcare/athome/approvedproviders/

- The **Race Equality Programme in Mental Health Care**[9] looks to enable more people to have access to support, advice and guidance to ensure good levels of mental health by working alongside statutory and voluntary mental health providers to ensure access to services for this group of people is considered and staff are trained appropriately.

- **Alzheimer's Society Carer Information and Support Programme (CrISP)**[10] provides support and up-to-date, relevant information in a group environment, where carers can share experiences and find out about local and national services that can offer support. See case study A at Appendix 2.

- We have also had our HelpMyGP and HelpMyA&E booklets translated into Arabic to support those moved here under the **Syrian Resettlement Programme**.

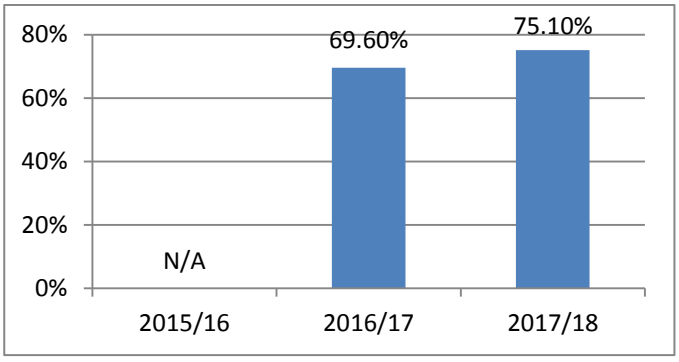
## 2.4 Desired outcome: people feel respected and able to make informed choices about services

2.4.1 A key indicator of this outcome is the proportion of people using services who feel they have been involved in making decisions about their support. In the outcomes framework this is measured in the following ways:

*Figure 5: Percentage of people using services who receive self-directed support*

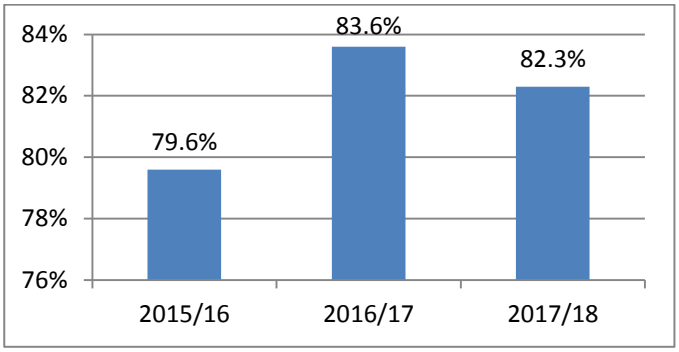
| | 15/16 | 16/17 | 17/18 |
|---|---|---|---|
| **East Sussex** | **100.0** | **100.0** | **100.0** |
| South East average | 90.3 | 94.6 | n/a |
| National average | 88.2 | 90.6 | n/a |

*Figure 6: People receiving services who feel they have enough choice over the care and support services they receive*




[9] news.eastsussex.gov.uk/east-sussex-better-together/wp-content/uploads/sites/10/2015/07/NIW2017-Promoting-race-equality-in-mental-health.pdf
[10] https://www.alzheimers.org.uk/about-us/our-dementia-programmes/carer-information-support-programme

*Figure 7: Percentage of people receiving services who feel they have as much control over their daily life as they want*




The percentage of people who receive self-directed support remains consistently at 100% which is above the South East and national averages. The proportion of people who feel they have enough choice over the care and support services they receive is increasing however fewer people are reporting they feel they have enough control.

2.4.2 We also consider whether carers feel respected and able to make informed choices about services by looking at the proportion of carers who feel they have been involved in decisions about services and those who feel their needs were taken into account when planning their support:

*Figure 8: Percentage of carers who feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care for. (Note: surveys are carried out every two years)*

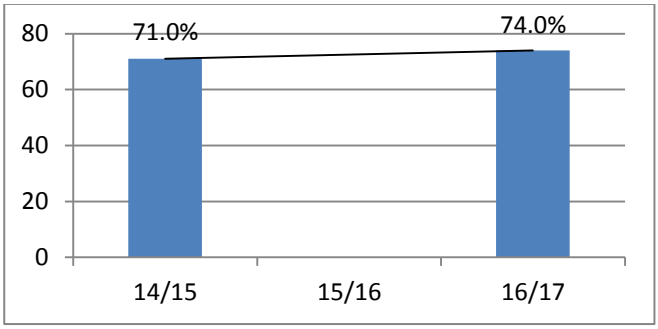
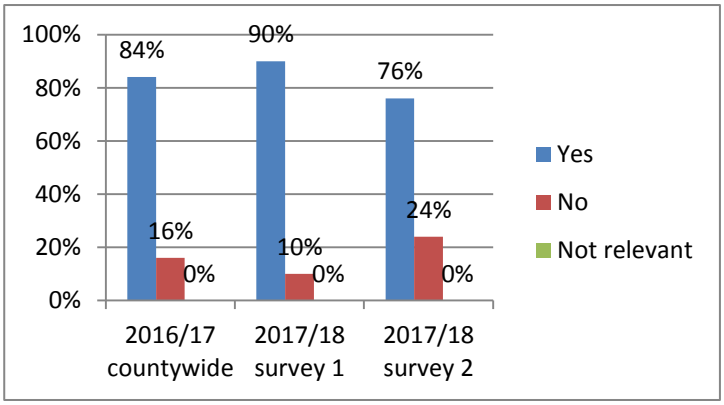



*Figure 9: Percentage of carers who feel that their needs as a carer were taken into account in planning their support*




The proportion of carers who feel they have been involved in decisions about services increased from 71% in 2014/15 to 74% in 2016/17 and was above the South East and national averages

however fewer carers reported feeling that their needs as a carer were taken into account in planning their support.

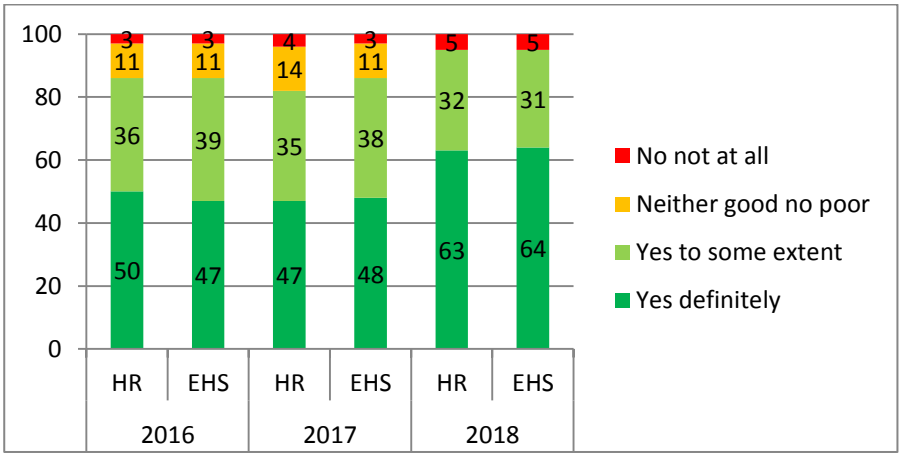
2.4.3 In 2017, **Children's Services** teams conducted satisfaction surveys. Headline figures show improvements are as follows:

- 99% felt that staff treated them with dignity and respect (2% increase from last year)
- 97% were generally happy with the service they received (1% increase from last year)
- 96% agreed that their needs, feeling and wishes had been taken into account (3% increase from last year)
- 68% stated that things had changed for the better as a result of working with Children's Services (comparable figure not available for last year)

2.4.4 Results from the latest **East Sussex Healthcare Trust (ESHT) inpatient survey** relating to care and treatment give a score of 7.2 out for 10 for whether people are as involved as much as they wanted to be in decisions about their care and treatment. In relation to leaving hospital and people being involved in decisions about their discharge from hospital, if they wanted to be, the score was 6.9 out of 10.

2.4.5 Results from the **national GP survey,** for Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG, relating to perceptions of care at patients' last appointment with a healthcare professional show that patients are feeling increasingly involved in decisions about their care and treatment:

*Figure 10: Percentage of people feeling involved in decisions about their care and treatment*




*(HR=Hastings and Rother, EHS=Eastbourne, Hailsham and Seaford)*

2.4.6 **Sussex Partnership NHS Foundation Trust (SPFT)** has developed a Carers' Charter[11]. The charter is a statement of the Trust's values, principles and standards across eight areas that carers have said are important: information; assessment; short breaks; emotional support; support to care; having a voice; a life beyond caring; and equality and diversity.

## 2.5 Desired outcome: people have choice and control over services and how they are delivered

2.5.1 A key indicator of choice and control is the number of people in receipt of direct payments for their care or personal health budgets and these numbers have been reducing over the last three years.

[11] https://www.sussexpartnership.nhs.uk/carers-charter

*Figure 11: Percentage of people using services who receive direct payments*

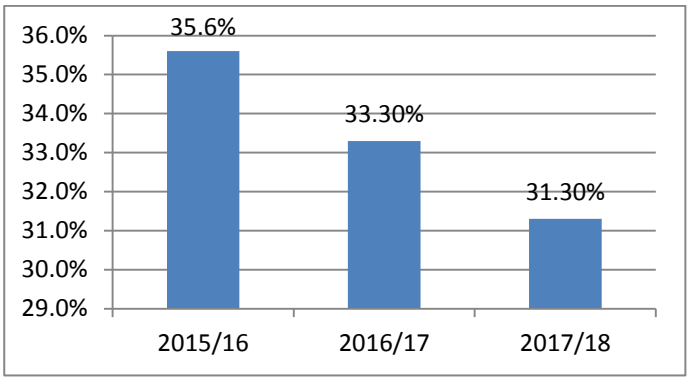
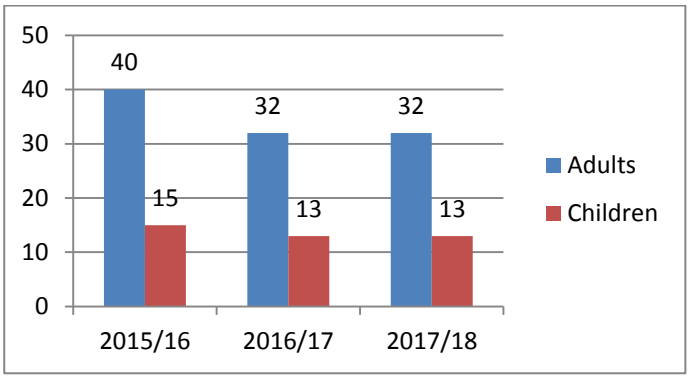



*Figure 12: Number of people in receipt of (continuing) personal health budgets*




2.5.2 Initial investigations into the declining number of clients with direct payments highlighted that clients required longer involvement than they had received previously at the start of their direct payment. Focussed back office support has been put in place to address this including extra visits and telephone conversation to explain the process and answer any questions that clients or their representatives may have. The proportion increased to 31.9% in the first quarter of 2018/19 which reflects that the number of clients that receive a direct payment has stabilised. The number of people in receipt of personal health budgets has also stabilised.

2.5.3 The majority of community mental health services encourage people to self-refer for support and all mental health community services include client engagement, involvement and co-production opportunities. A dedicated service, People in Partnership (PiP)[12], works with people with mental health problems, their families and carers, to be engaged to represent client and carers views on service delivery and design. They influence and lead commissioning decisions, support the development of good quality, performance and outcomes of services and the effectiveness of care pathways.

2.5.4 Within this outcome we also look at the percentage of carers who receive direct payments which at 100% in East Sussex is above the national and South East average.

*Figure 13: Percentage of carers using services who receive direct payments*

| | **15/16** | **16/17** | **17/18** |
|---|---|---|---|
| **East Sussex** | **100** | **100** | **100** |
| South East average | 90.0 | 94.4 | n/a |
| National average | 84.7 | 87.8 | n/a |

[12] southdown.org/mental-health-recovery/people-partnership-east-sussex

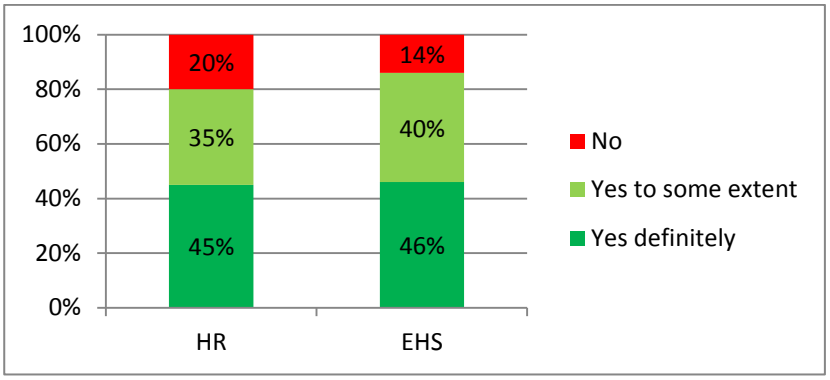
2.5.5 Carers personal budgets are allocated following a carer's assessment that identifies eligible support needs. This is a one-off direct payment to help carers with unmet eligible support needs identified in their carer's assessment/review. It is used if the carer cannot be supported by existing community services, and/or by meeting the care and support needs of the adult they are caring for. In 2017/18, carers personal budgets were allocated to 4,459 carers following assessment/review and the average payment was £170. The annual budget for carers personal budgets is £750K. Examples of spend include gym membership; washing machine; travel costs and respite.

2.5.6 Personal budgets are also offered to young carers and the annual budget for young carers personal budgets is £40K. Examples of spend include laptops; school trips; sports and out of school activities such as dance; Scouts; swimming; counselling and childcare for younger siblings.

## 2.6 Desired outcome: people are as independent as possible

2.6.1 A key indicator within this outcome is the number of people living at home and accessing support in their communities. Options for quantitative measurement of this indicator are being explored and could include measures such as support with managing long-term health conditions. There is a new question in the national GP survey that asks people whether they have had enough support to manage their long-term health condition so there is no data for previous years however performance in both CCGs is above the national average.

*Figure 14: "In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)?*




*(HR=Hastings and Rother, EHS=Eastbourne, Hailsham and Seaford)*

2.6.2 Achievement of this outcome is supported by a range of services including:

- **Joint Community Rehabilitation** (JCR)[13] service helps people stay as safe and mobile as possible at home and in the community, while also building up their strength and fitness, perhaps following an operation or period in hospital. Occupational therapists from both health and social care backgrounds work with physiotherapists and support workers to help people restore or minimise loss of function and maximise their independence and/or wellbeing.
- **East Sussex Better Together Benefits and Debt Advice Project** (BDAP)[14] enables people to access their correct benefit entitlements and offers free, expert advice on managing debt to those with long-term physical or mental health conditions. In 2017/18:
    - More than 10,000 people received benefits and debt advice.

[13] http://news.eastsussex.gov.uk/east-sussex-better-together/whats-improving/better-community-services/joint-community-rehabilitation-jcr-service/
[14] http://news.eastsussex.gov.uk/east-sussex-better-together/2018/08/20/money-advice-service-is-helping-local-people-take-back-control-of-their-finances-and-their-health/#more-2842.

- Over £8.4million in annualised benefit income and one off claims was realised for clients.
- 80% of respondents said their mental wellbeing had improved following support from the Benefits and Debt Advice Project.
- The project supported:
  - 7,897 people with long term health conditions
  - 2,758 older people
  - 2,020 families with children
  - 1,355 people at risk from becoming homeless
- The expert debt service supported over 700 people, managing debts totalling £4.4million.
- 1,000 people have been referred by health and social care professionals or at outreach sessions delivered from health and wellbeing locations.

- **Support with Confidence**[15] provides a directory of vetted and approved personal assistants and care and support providers who can help people at home.

- **Integrated Community Equipment Services** (ICES) are jointly commissioned services that provide community equipment and installations, bespoke adaptations and equipment for people with sensory impairments.

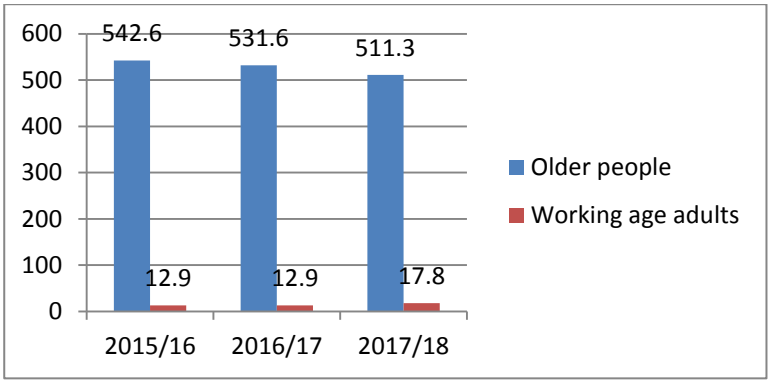
- **Locality Link Workers**[16] work with frontline health and social care to grow assets and networks and encourage the development of stronger, more resilient communities which will help to keep vulnerable people active and well. The case study at Appendix 3 shows how a Locality Link Worker's involvement helped someone to stay living at home.

- **Association of Carers**[17] provide a range of services that support unpaid carers to be as independent as possible through free, high quality, volunteer-led services that encourage independence and reduce isolation:
  - A carer who benefited from the **Computer Help at Home** service said: "*My volunteer is so caring, professional and tolerant. I am 77 years old, and for the first time I have felt empowered to learn computer skills.*"
  - Another carer whose husband had managed the technology in the home before coming unwell had been supported to shop online, talk to her family via FaceTime and set up ICE on her mobile phone (In Case of an Emergency).
  - Case study B at Appendix 2 shows how the volunteer respite prevented a crisis and supported someone to remaining at home while their carer was in hospital.

2.6.3 The number of people who are permanently admitted to residential and nursing care homes is one measure of people living as independently as possible:

[15] https://www.eastsussex.gov.uk/socialcare/support-to-stay-at-home/support-with-confidence/
[16] http://news.eastsussex.gov.uk/east-sussex-better-together/2017/12/12/so-you-think-you-know-locality-link-workers/
[17] http://associationofcarers.org.uk/

*Figure 15: Rate of permanent admissions to residential and nursing care homes*




The rate of older people being permanently admitted to residential and nursing care is steadily reducing which is positive however the 2017/18 rate of permanent admissions of working age adults is showing an increase on 2016/17. This is due to a range of reasons including high level of need.

2.6.4 The number of people accessing Technology Enable Care Services (TECS) has been added to the framework for 2018/19 to help measure the number of people living at home and accessing support in their communities. We promote the use of Telecare equipment in the community wherever it is suitable for the needs of the individual. This includes a range of personal and health monitoring devices that enable people to remain safe and independent at home.

2.6.5 A key indicator of people being as independent as possible is the proportion of people with support needs in paid employment. Public Health England recognise that employment is a primary determinant of health, impacting both directly and indirectly on the individual, their families and communities. Unemployment is associated with an increased risk of mortality and morbidity, including limiting illness, cardiovascular disease, poor mental health, suicide and health-damaging behaviours. The indicator is measured for people with learning disabilities and those in contact with secondary mental health services in paid employment:

*Figure 16: Percentage of adults with learning disabilities in paid employment*

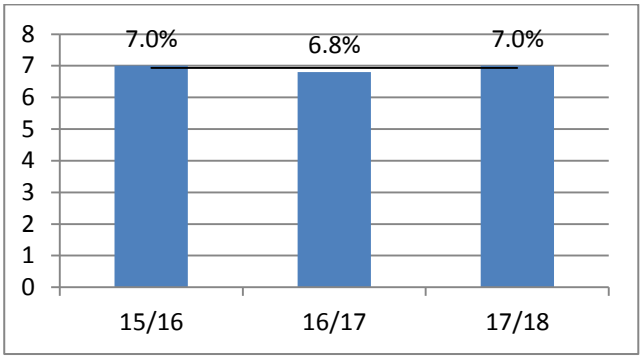
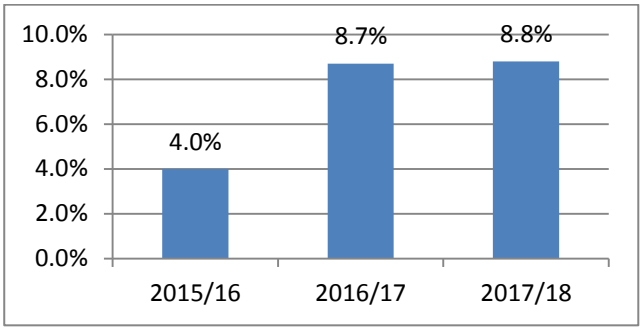


*Figure 17: Percentage of adults in contact with secondary mental health services in paid employment*




2.6.6 **East Sussex Supported Employment Service**[18] supports people to gain and retain paid employment through an approach called Individual Placement and Support (IPS)[19]. It is internationally recognised as best practice to supporting people with mental health challenges to secure or retain paid work. The providers, Southdown, are the largest provider of IPS in the UK and are recognised as an IPS Centre of Excellence by the Centre for Mental Health.

2.6.7 **Let's Get Working**[20] supports people with long-term health issues and disabilities to take the next steps towards volunteering, working and getting involved in their local community. Since 2017:

- 215 people with disabilities or long term illnesses have been supported
- ¾ of people were previously economically inactive
- 16 have already gained employment
- 78% are more active in the labour market
- 65% report significantly improved mental health
- 63% improved everyday living conditions
- 60% more family or community connections
- 50% report reduced need for medicalised intervention or greater ability to self-manage conditions

Quotes from people using the service also highlight its value to individuals:

- "This is totally different to any other service, so much more positive"
- "I needed education, not medication"
- "Makes you feel like you can do what you want to"
- "Its positive action rather than just talking"

2.6.8 Another key indicator within this outcome is the proportion of people who regain their independence after using services. This is measures by the proportion of people aged 65 and older who are still at home three months after a period of rehabilitation and the proportion of people needing less acute, or no ongoing, support after using short-term services:

[18] https://www.southdown.org/mental-health-recovery/our-employment-support
[19] https://www.centreformentalhealth.org.uk/what-is-ips
[20] http://sussexcommunity.org.uk/work-learning-volunteering/lets-get-working/

*Figure 18: Proportion of people 65+ who are still at home three months after a period of rehabilitation*

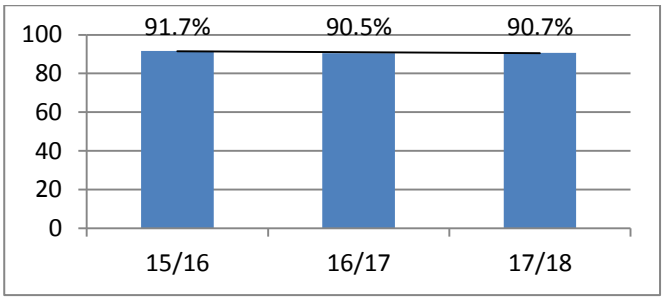
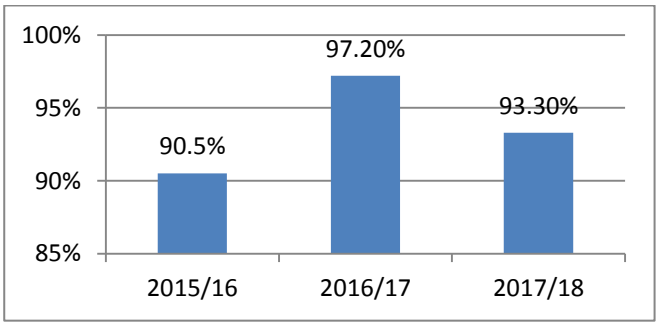



*Figure 19: Proportion of people needing less acute, or no ongoing, support after using short term services*




Performance shows a downward trend from 2016/17 to 2017/18 however there has been an overall improvement over the three year period.

2.6.9 There are a range of services that help to achieve these outcomes and examples of compliments received show that they continue to be valued:

- **Occupational Therapy (OT) and Reablement Services:** "Thank you to the OT Team for all of your help. You have been so very helpful, supportive and understanding. You have helped me make a remarkable recovery following breaking my pelvis in three places, one of which was shattered. It is amazing and I am very grateful to everyone. I am blind and often find that people do not treat me as an individual but the team treated me as an individual and I can't say how much I appreciated that. Having spent 9 months in hospital I am now back living independently in my own home due to your support."

- **Sensory Impairment Reablement Services:** "Thank you and your team for all the help and support I have received. I want to let you know how it has changed my life and made life so much brighter despite the darkness and dark times. I have been overwhelmed by the help offered and cannot thank you all enough for everything you have done. Me and my family would not have known where to start accessing groups and equipment and the signposting and assistance has been second to none."

- **Joint Community Rehabilitation (JCR)** remains key to ensuring people regain their independence after using services and client feedback
    - "Everything was client based and was exactly what was needed"
    - "I can now go up and down stairs easier. I have also been able to sit out in the garden with confidence"
    - "I can now enjoy my shower again – on my own!"

## 2.7 Desired outcome: people feel safe

2.7.1 A key indicator of the experience of local people is the proportion of people and carers who report feeling safe. The health and social care system plays a key role in helping people with care

and support needs, and their carers, feel safe the environment and other agencies have an important influence (e.g. the police).

*Figure 20: Percentage of people who feel as safe as they want*

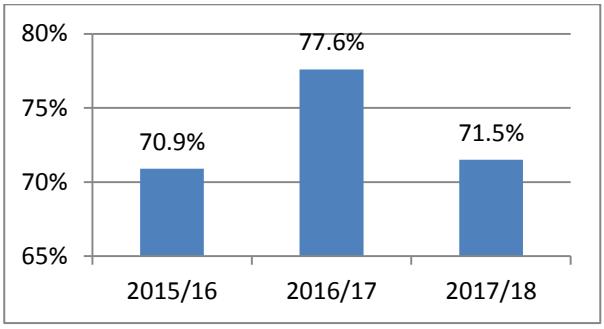
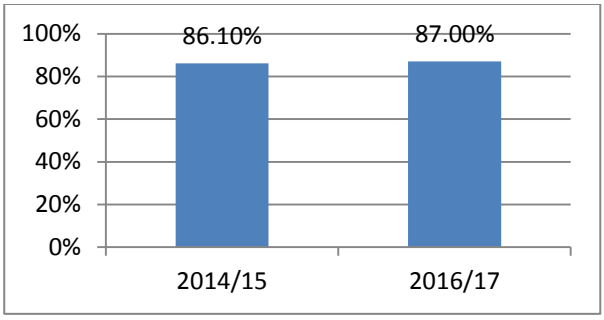



*Figure 21: Percentage of carers who feel safe and have no worries about their personal safety is increased (surveys are carried out every two years)*




The data shows an overall improvement in people using adult social care services feeling as safe as they want over the three year period however the percentage reduced in the last year. There was slight increase in the proportion of carers who feel safe and have no worries about their personal safety.

2.7.2 The reasons why people respond to these questions in the way they do can vary significantly and can be influenced by a range of factors. Our priority is to support those people in our community who are vulnerable and/or at risk of abuse. There are a wide range of ways in which we do this; some of them are highlighted below.

2.7.3 The **'Health Independent Domestic Violence Advice Service' (HIDVA)**[21] is working with primary care professionals (such as GPs), community healthcare staff, midwives and patients to improve the identification of domestic violence and abuse, and make sure people are referred to the right support. The service is also supporting Conquest Hospital staff, including the A&E department, doctors, nurses, and reception. A midwife working with an Advisor at Conquest Hospital said;

*"Having the new Advisor working with maternity will make sure women receive the appropriate referral and guidance. Having a specialist worker that supports and guides maternity staff will also be invaluable. She can help women make choices to keep themselves and their children safe. Our advisor has only been with us for a few months but the work she is doing and the support she offers to women and staff is of huge benefit."*

[21] http://news.eastsussex.gov.uk/east-sussex-better-together/2018/08/17/specialist-service-improves-support-for-people-affected-by-domestic-violence-and-abuse/#more-2828

2.7.4 In Children's Services, a total of 3,089 Year 10 pupils (14 and 15 year olds) from all state funded secondary schools in East Sussex and the Pupil Referral Unit took part in the **East Sussex Health Related Behaviour Survey** (a 65% participation rate)[22]:

- 87% of Year 10 students rate their safety during the day as good or very good in 2017 - up from 84% in 2012.
- 97% of Year 10 students say they have been told how to stay safe online in 2017 - up from 87% in 2012.

2.7.5 **East Sussex Against Scams Initiative** SCAMbassadors, SCAMchampions and Friends are all part of the National Trading Standards Scams Team's Friends Against Scams initiative[23], a tool used to help keep people safe by raising awareness about scams.to date:

- 2,247 people have attended a Friends Against Scams awareness session
- 101 organisations are supporting the East Sussex Against Scams Partnership project
- There are 68 'SCAMchampions' in East Sussex
- There are 14 'SCAMbassadors' in East Sussex

## 3. Conclusion and reasons for recommendations

3.1 This focused report on the experience of local people domain highlights progress towards achieving the ESBT aim to deliver sustainable health and social care that better meets the needs of local people, offering high quality care at the right time, in the right place. It gives examples of the range of activity across the system aimed at improving the experience of patients, people who use social care services and carers and shows how quantitative data can be supplemented with qualitative information to give a broader picture of progress.

3.2 There are improvements in key areas for example:

- More people and carers report they find it easy to access and use information about services.
- More people using services feel they have been involved in making decisions about their support.
- More people in contact with secondary mental health services are in paid employment.
- We are maintaining the proportion of carers in receipt of direct payments at 100%.

3.3 However fewer carers are feeling their needs were taken into account in planning their support, there was a slight increase in the number of people reporting they have had to keep repeating their story and performance in a number of areas is stable rather than improving. This is being monitored closely and if current trends continue further work will be undertaken to understand the reasons behind this.

3.3 The ESBT Strategic Commissioning Board is recommended to:

- Note the progress made with identifying and securing data to further understand our performance on a system-wide basis.
- Note the highlights shown here as examples of how we can start to measure outcomes in the experience of local people domain on a system-wide and population basis, and the actions being taken with a view to improving outcomes.

[22] Source: 2017 East Sussex Health Related Behaviour Survey for Year 10

[23] https://www.friendsagainstscams.org.uk/article.php/11/how_can_i_get_involved/7532fdc1a51736c7ae59d8c5c958a407

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BACKGROUND DOCUMENTS

None

Appendices

Appendix 1: Quality care and support domain

Appendix 2: Carers case studies

Appendix 3: Cooking up a sense of camaraderie: The Men's Meals project

## Appendix 1: The experience of local people

# The experience of local people

| Outcomes | These indicators and measures will tell us how we are doing... | | |
|---|---|---|---|
| **We want good communication and access to information for local people** | | | |
| Health and care services talk to each other so that people receive seamless services | The proportion of people and carers reporting they have only had to tell their story once | ⇨ | The percentage of people who contact us about their support, who have not had to keep repeating their story, is increased<br>The percentage of carers who contact us about their support, who have not had to keep repeating their story, is increased |
| Jargon free health and care information can be found in a range of locations and formats | The proportion of people and carers reporting they find it easy to access and use information about services | ⇨ | The percentage of people who find it easy to find information and advice about support, services or benefits is increased<br>The percentage of carers who find it easy to find information and advice about support, services or benefits is increased |
| **We want to put people in control of their health and care** | | | |
| People feel respected and able to make informed choices about services | The proportion of people using services who feel they have been involved in making decisions about their support | ⇨ | The percentage of people using services who receive self-directed support is maintained<br>The percentage of people receiving services who feel they have enough choice over their care and support services is increased<br>The percentage of people receiving services who feel they have as much control as they want over their daily life is increased |
| | The proportion of carers who feel they have been involved in decisions about services | ⇨ | The percentage of carers who feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care, for is increased<br>The percentage of carers who feel that their needs as a carer were taken into account in planning their support is increased |
| People have choice and control over services and how they are delivered | The number of people in receipt of direct payments for their care or personal heath budgets | ⇨ | The percentage of people using services who receive direct payments for their care is increased<br>The number of adults in receipt of a personal health budget for their continuing healthcare is increased<br>The number of children and young people in receipt of a personal health budget for their continuing care is increased |
| | The proportion of carers in receipt of direct payments | ⇨ | The percentage of carers using services who receive direct payments is maintained |
| **We want to deliver services that meet people's needs and support their independence** | | | |
| People are as independent as possible | The number of people living at home and accessing support in their communities | ⇨ | The number of people accessing the support available to them in their local communities is increased<br>The number of people are permanently admitted to residential and nursing care homes is reduced<br>The number of people accessing Technology Enabled Care Services (TECS) is increased |
| | The proportion of people with support needs who are in paid employment | ⇨ | The percentage of adults with learning disabilities in paid employment is increased<br>The percentage of adults in contact with secondary mental health services in paid employment is increased |
| | The proportion of people who regain their independence after using services | ⇨ | The percentage of people 65+ who are still at home three months after a period of rehabilitation is increased<br>The percentage of people needing less acute, or no ongoing, support after using short-term services is increased |
| People feel safe | The proportion of people and carers who report feeling safe | ⇨ | The percentage of people who feel as safe as they want is increased<br>The percentage of carers who feel safe and have no worries about their personal safety is increased |

## Appendix 2: Carers case studies

### Case study A: CrISP training – information and advice

Mrs A (88), whose husband was diagnosed with vascular dementia 18 months ago, attended the CrISP1 course with her daughter.

Through the session on 'legal and money matters' she was made aware that her husband no longer had capacity to deal with financial matters and that is was therefore necessary to get the existing enduring power of attorney (EPA) registered. The following week she informed the service that she had contacted her solicitor and everything necessary was being arranged.

She started the course feeling quite depressed and low. Through attending the course she was made aware of a carer support group for herself nearby, as well as a supper club she could attend with her husband. She was unsure about attending by herself, but developed a friendship with another lady on the course, and they arranged to go to both groups together in the following month.

During the session on meaningful activities and daily activities she was able to discuss her concern that her husband appears to be no longer showing interest in activities. Through discussion and information provision she has now bought dementia specific puzzles, which he very much enjoys and she is planning to make him a memory box and album.

Mrs A's husband general physical health is not well. Through the course she became aware of other health reasons that could make his dementia appear worse and has now booked for a hearing test for her husband as well as encouraging him to take in more fluids to stay hydrated.

Comments from group evaluations include:

- The group gained lots from shared experiences and felt that they had learned from others.
- They appreciated being given 'loads' of printed information.
- "Emma shared information with empathy and understanding."
- "The size of the group helps. It is helpful to share with the group realising you are not on your own."
- "It has given us answers to situations we might not have thought of."

### Case study B: Association of Carers Volunteer Respite

Our respite volunteer S has been providing a regular respite break for carer D for several months. D cares for his wife A, who has osteoporosis, arthritis, poor mobility, diverticulitis and poor hearing. During one regular visit, D went out on his bicycle (he is a keen cyclist) and fell off was taken to hospital with a bump to the head and a knee injury. He telephoned S and updated her on the situation and called Lifeline who contacted adult social care (ASC) to put his Carer Respite Emergency Support Scheme (CRESS)[24] plan into action.

S then took several calls from ASC who explained that emergency contacts were the neighbours but they were not able to contact them. S acted as an intermediary between ASC and the cared-for A. Due to A's poor hearing and limited mobility, this would have proved extremely difficult, if not impossible, if A had been alone.
S successfully contacted the neighbours when they returned home and arranged for them to sit with A after her respite visit finished. S also spoke with ASC regarding overnight support for A and meals being delivered.

D remained in hospital for a week. During this time S kept in contact with A and the neighbours to ensure support was in place.

[24] https://www.eastsussex.gov.uk/socialcare/carers/respite/emergency/

**Appendix 3: Cooking up a sense of camaraderie: The Men's Meals project**

Take a cup of cookery training tailored for older men, add a healthy dash of social interaction, mix them up in a supportive community venue and what have you got? A sure fire recipe for health and wellbeing that hits a target audience that needs some help.

One of East Sussex Better Together's (ESBT) earliest innovations was the introduction of six Locality Link Workers. They provide a vital link between frontline health and care services and the voluntary and community sectors, creating a network of information about local projects, clubs and initiatives, which can support people to keep well and feel less isolated.

Min Stone is the Locality Link Worker that covers Seaford and was instrumental in setting up the Men's Meals project in the town. "I work closely with our Proactive Care Practitioners (PCPs) and Community Nursing teams and they were often telling me about older men on their patches, who lived alone, weren't getting out much and were resorting to 'TV dinners' because they weren't confident in cooking for themselves," she explains.

This planted a seed that grew into the Men's Meals project. With help from the Sussex Community Development Association, who trained the volunteer who would lead the cooking sessions, and enthusiastic support from St James' Trust in Seaford, who provided the venue for the courses, the project was soon 'cooking on gas'.

Bryan Turner, Managing Director of St James' Trust and an ex-chef himself, was delighted to be involved. "It's gone really well and we've had some really great feedback from the guys who took part," he explains. "Not only have they learned that there's more to eggs than just scrambling them, they've also found out about nutrition and hygiene too. It's been a real success so St James' are keen to develop this project for the future, maybe turning it into more of a lunch club. The whole experience has been a win-win all-round – helping our local residents to be healthier and happier, which in turn helps our health services."

"I have been delighted by the enthusiasm that Seaford has shown for the project and St James' have been so brilliant in picking it up and running with it," says Min Stone. "It's a really sustainable idea and with the level of local support I'm sure it will carry on and benefit even more people."

Local resident, Roger, attended two Men's Meals courses at St James' Trust: "My wife died three years ago so now I'm catering for myself. The thing you find as a single person is that you tend not to try new things and I was relying too much on ready meals, which my daughter wasn't happy about! It was nice to talk amongst ourselves in the group, we were quite a friendly bunch and got on well together – camaraderie developed between us all. It was good to push yourself out of your comfort zone and do something different."

Roger now has a real 'taste' for cooking and has signed up to a subscription-based recipe box service to keep trying new things – watch out MasterChef!