

Transforming health and social care in East Sussex

East Sussex Better Together

Presentation to the Health and Wellbeing Board 28th April 2015



East Sussex Better Together What will we cover today?

- Background and overview of East Sussex
- East Sussex Better Together: Vision & Framework
- Whole system transformation in 150 weeks
- The ultimate aim
- The challenges we face
- Next Steps





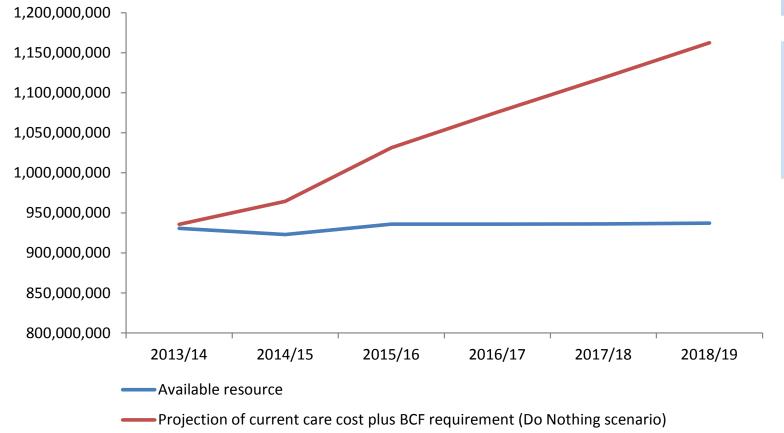
Background to East Sussex

- Across the County Council and Clinical Commissioning Groups we spend around £935 million every year on commissioning health and social care (planning and buying the majority of local services)
- The services we provide at the moment, whilst often good, are not always the services that best meet the needs of how we live our lives today
- More than half the total spend is for people over 65 years (for health spend it is 54%).
 Patients over 85 years use on average health and social services equivalent to £8,180 per year as compared with £1,740 average for all other age groups in East Sussex
- Our population is growing, people are living much longer and developing multiple long term conditions – the demand for local health and care services is growing faster than our budget





Projection of current resource use in a 'do nothing' scenario highlights challenge ahead for East Sussex







East Sussex Better Together Vision

Our vision is to create a **sustainable** health and social care system that promotes health and wellbeing whilst addressing quality and safety issues, in order to prevent ill health and deliver improved patient experience and outcomes for our population. This will be delivered through a focus on population needs, better prevention, self care, improved detection, early intervention, proactive and joined up responses to people that require care and support across traditional organisational and geographical boundaries.

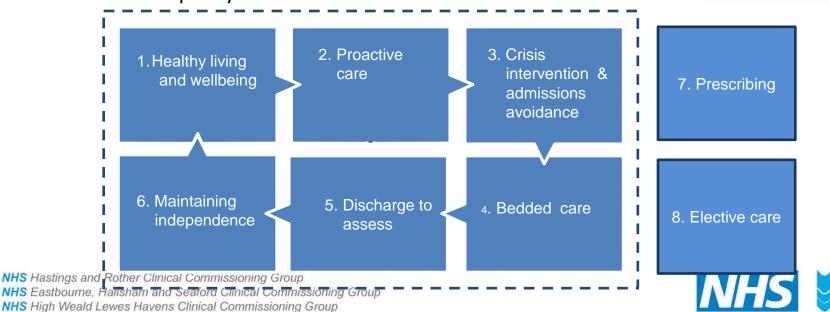


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East Sussex Better Together Framework

A single framework to cover 100% of what we do, bringing together the entire spectrum of services people need to be fully supported at every stage of their health and social care needs

- The first six boxes bring together our aspirations to focus on proactive care in order to meet people's needs, make sure services are joined-up and prioritise services that help people be more independent.
- The second two focus on the very important aspects of 'prescribing' and 'elective care' (e.g. surgery and other planned care) where we believe we can make big improvements in value and service quality



A snapshot of public engagement so far

We want to make sure local people help shape local services







Partnership Working

- Shaping Health and Social Care and service design groups
- Patient participation group forums,
- Critical Friends Partnership,
- Partnership Boards,
- Client and carer forums,
- East Sussex Seniors Association Health and Community Care Theme Group
- Individual working group forums





Words into action Care Design Groups

The way we are bringing the 6+2 box model to life for local communities is through a Care Design Group (CDG) approach.

- Over 40 health and social care professionals, voluntary sector and patient and public representatives have come together in a care design group
- This is a process that helps us to review peoples health and care needs and look at services we need to commission to meet these needs

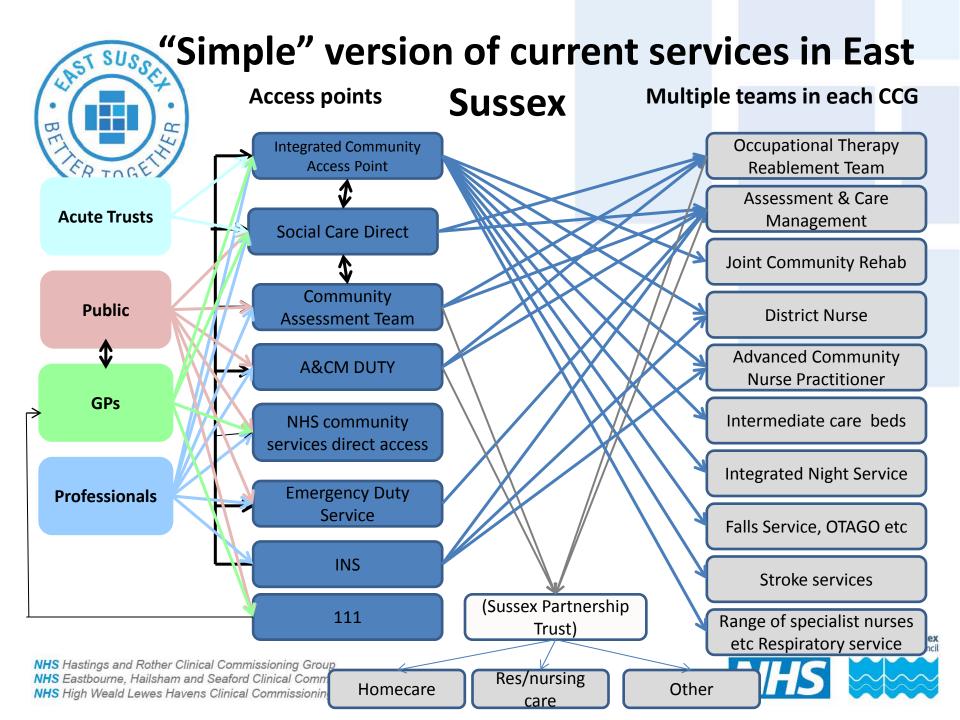
Priorities for development:

- How to make access to services easier
- How to better design services for people around a community
- How to access services on an urgent basis or in an emergency



A complex picture 4 CIIO **Locality-Based Community** East Sussex 24/7 Urgent Team **Health and Care** Responsible for all health and Single Point of Access care needs of Bexhill residents 111 GP Out of hours Allied Health Professional Advice and Response (Social Care, Nursing, Mental Health) Professionals Care planning GP Patient Tracking and Call Back Care co-ordination Health Care delivery: Care Supported self care System Capacity Management Assistants Using community assets for health and wellbeing Deploys Dischargein Falls services Urgent GP Step-Up Bed Mental Team assessment in Visit End of Life Care Health Admin Very Frail Supported early led "front end" Nurse discharge Acute Clinic Ambulance Reablement/ Frail Rehabilitation Symptom-Based Pathways Social Vulnerable Care Acuté Patient Integrated Rapid / Client Response (Step-Well Up and Down) hospital Community and Care Homes Primary care Voluntary Multi-disciplinary clinical decision Case Sector Manager Community District Hospital Nurse Specialist Support Generalist

Shared Electronic Record Medicines Management



Future access model Phase 1 - Adults Multiple teams in each CCG Access points 111 NST's for any **Acute Trusts** community nursing, social care worker or therapy/reablement input **Public** SINGLE POINT OF **ACCESS FOR ADULT** Intermediate care beds **HEALTH AND x8 SOCIAL CARE GPs** INS x3 Range of other EDS, PSL, CHILDREN community health and AND MH **Professionals** social care services e.g. **INCLUSION IN END** Respiratory service STATE MODEL TO Stroke rehab BE DETERMINED. IF Continence **AGREED Blue Badges** (SPT) **IMPLEMENTED AS** Carer's services PHASE 2 County Council Res/nursing Other Homecare care



Future Single Point of Access delivery model

Professionals GPs Level 1 Level 3 Level 2 General information, Professional support Contact assessment. advice & signposting nurse Triage Resolution at point of therapy, **Public** Coordinate response social care worker contact Arrange simple Collect basic services information and Feedback to referrer screen for onward assessment

Receiving services

- Voluntary/third sector
- Non statutory services
- Some statutory services e.g. Blue Car Badge, GP,

NHS Hastings and Rother Clinical CommisContinence service

NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group NHS High Weald Lewes Havens Clinical Commissioning Group

Receiving services

- Neighbourhood Support Teams
- Other Health and Social Care services
- Voluntary/third sector
- Non statutory services







Integrated Community Health & Social Care teams - Adults

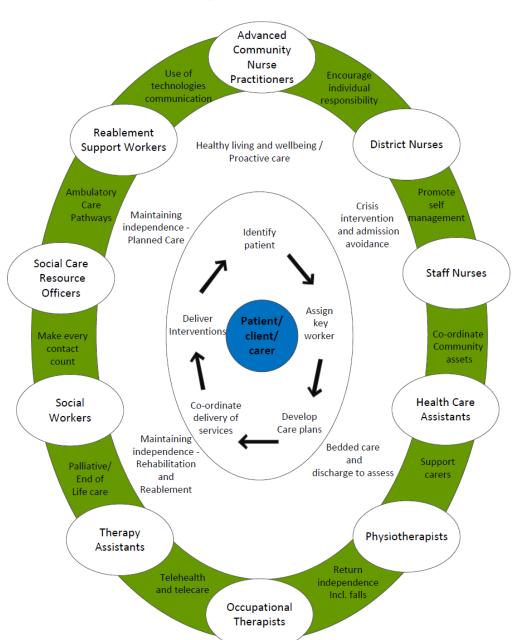
Overarching proposal to change the way services are provided to deliver proactive joined up care; promote independence and improve outcomes for adults in locally defined communities

- Proactive care to actively identify people with complex needs and help people to manage their long term conditions more effectively
- Crisis intervention and admission avoidance
- ➤ In-reach into bedded care and supporting discharge to reduce length of stay in hospital
- Maintaining independence rehabilitation and reablement integrated across health and social care
- Maintaining independence planned and routine care by nurses and social care





The core integrated locality adult team

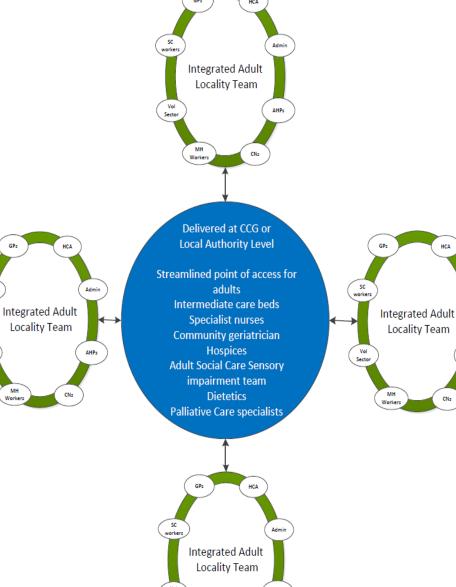


Overview of locality team made up of nursing, therapy and social care delivering full range of functions for that locality





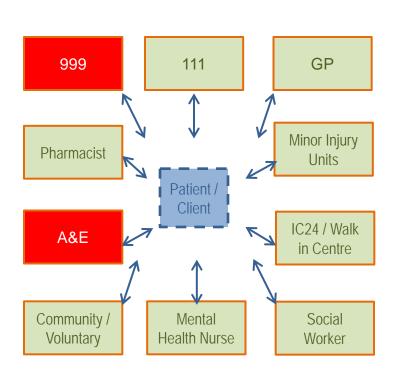
SC workers

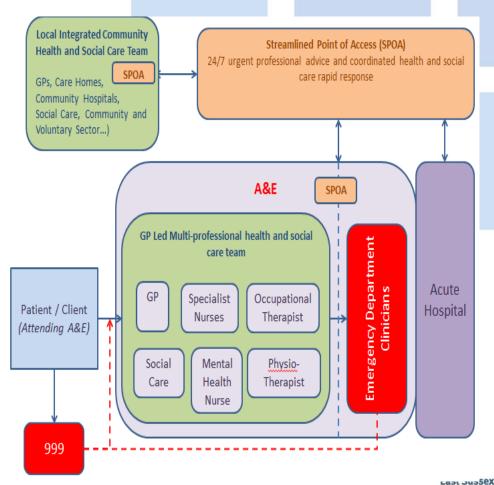


Locality
teams fit into
the broader
adults
community
services and
pull on
services
delivered at a
CCG or
county level



Current and proposed urgent care landscape











Maintaining the pace

Whole system transformation in 150 weeks

Delivering the 6 Boxes		2015/16
Streamlined Points of Access	Phase 1 (Adults) Go-live:	Q1
Integrated Locality Teams	Phase 1 (Adults) Go-live	Q3
Whole System Urgent Care	Options Appraisal	Q1
Self-care and Prevention	Scoping of existing services, apps & technology	Q1
Delivering the 'Plus 2' Boxes		2015/16

Delivering the 'Plus 2' Boxes		2015/16
Medicines Optimisation	New services agreed	Q2
Planned Care	Programme Plan agreed	Q2

Nine Enable	Nine Enablers					
Patient Publi	c Engagement	Governance and Decision Making	Strategic Planning			
Innovation a	nd Research	Financial Planning	Workforce Planning			
Primary Care	Strategy	Provider Landscape	IM&T			



East Sussex Better Together

The ultimate aim of the programme

A fully integrated health and social care economy in East Sussex that makes sure people receive proactive, joined up care, supporting them to live as independently as possible

What will this look like?

- Improved health and well being with reduced health inequalities
- a sustainable approach to community resilience and primary and secondary prevention
- Our experiences of using services will be better
- Our staff will be working in a way that really makes the most of their dedication, skills and professionalism
- The cost of care will have been made affordable and sustainable

We will have secured the future of our NHS and social care for the next generation







Challenges

- Sustaining and improving current services during a period of transformation
- Meeting the immediate requirements of the Better Care Fund to reduce demand on hospitals whilst ensuring any service developments support the delivery of our strategic goals
- National organisational changes to the NHS and social care
- Significant budget reductions to social care
- Sustaining a focus on health and wellbeing and prevention
- Delivering significant cultural, behaviour and organisational change

Maintaining a locally led programme of transformation which delivers

the best possible outcomes within available resources

NHS Hastings and Rother Clinical Commissioning Group.







Next Steps - Engagement

- Strong communication and engagement group to ensure appropriate input as we continue to co-design services
- Developing a Public Reference Group to ensure we engage as many people of East Sussex as possible
- Working with all stakeholders to develop and refine the proposed new service models
- Building local partnerships with community based teams

