# Update on the progression of the Connecting 4 You Programme

## High Weald Lewes Havens CCG – November 2017

## 1. Background

High Weald, Lewes and the Havens (HWLH) is a large area without an acute hospital meaning that patients have to travel to one of three neighbouring ones. This complex patient flow has not always been recognised by local services. HWLH has an older than average population, high levels of frailty and pockets of poverty and health inequalities. Often patients struggle to understand their health and care services, as different organisations are responsible for different stages of their care.

Coupled with this complex geography and demographics there is also the backdrop of unprecedented financial challenges as well as unsustainable pressure on all parts of the health and social care system due to ever increasing demand and universal workforce recruitment difficulties again across the whole system from care homes to therapists to hospital doctors and general practitioners.

In recognition that no single organisation will be able to address these challenges and meet the needs of the population of HWLH a strong partnership approach is needed. In response the Connecting 4 You (C4Y) Programme was initiated in 2016 building upon developments done at an East Sussex level in preceding years, to transform the delivery of health and social care services across the HWLH Clinical Commissioning Group (CCG) area. This enabled the focus of integration of services to be developed at a bespoke and targeted level with relevant stakeholders.

C4Y is a partnership led by East Sussex County Council (ESCC) and HWLH CCG and covers the whole population of HWLH. The partnership includes;

- Primary Care
- Healthwatch East Sussex
- ESCC Adult Social Care and Children's Services
- Public Health
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Third and Voluntary Sector
- Wealden and Lewes District Councils

## 2. Introduction

At the meeting of the East Sussex HOSC in June 2017 there was a presentation given detailing the development of the Connecting 4 You (C4Y) Programme. It was noted that the building blocks of C4Y were firmly in place and HOSC Members requested an update on the 'delivery' of the programme later in 2017.

This report has been produced in response to that request and is split into four sections. The first section offers a high level update in regards to the development of the comprehensive C4Y Programme Plan, to stakeholder engagement, the progression of the accountable care model for HWLH and the C4Y governance arrangements.

The report then details three main areas as examples where significant progress can be seen in terms of tangible deliverables. These include;

- Urgent care systems and readiness for winter pressures; a range of initiatives to ensure integration of the whole system and that it is best able to respond to the current and increasing demands on the health and social care system across the HWLH area of East Sussex.
- The Dementia Golden Ticket – the expansion of an award-winning transformational new model of care
- The development of the Lewes Health Hub and Primary Care Home; the true integration of health and social care services in Lewes, delivering a 'community of practice'.

## 3. Progression of the Connecting 4 You Programme

### 3.1 Engagement with the public and wider stakeholders

There continues to be a high priority placed upon ensuring regular and meaningful engagement with the general public and wider stakeholder groups such as the East Sussex Seniors Association (ESSA) and Patient Participation Groups (PPGs).

The C4Y Programme has supported the development of the new Countywide Partnership and Engagement forum and will have a formal representative on the group. The important next step is to determine how the patient and service user experience and perspective that will be captured by this new forum will be used to meaningfully inform the development of the C4Y Programme and its component projects.

In September 2017 as part of the wide ranging and ongoing engagement for the programme, a C4Y Shaping Health and Social Care event was held in Crowborough. This was very well attended with around 60 participants.

The first part of the event was used to update on some key current transformational initiatives including;

- Re-procurement of 111
- Development of Urgent Treatment Centres
- GP Out of Hours service
- Initiatives to pro-actively support those living with frailty

These were well received with widespread support and also useful challenges in regards to specific details such as the pressing need to ensure widespread access to a patient's summary care record throughout the whole health and social care system.

The second part of the event was an opportunity for participants to offer feedback on their experience of using services, both positive and negative, to help shape the focus and development of all aspects the C4Y Programme.

A follow up C4Y Shaping Health and Social Care event is being planned for early 2018 in the Havens area. Discussions have already commenced with the C4Y partner agencies to determine if there are any key initiatives they would like to use the event to engage with the public on.

During 2018 there will also be opportunities for members of the public and wider stakeholders to engage on more localised issues both directly and through partner organisations to help support the development of the four Communities of Practice (COPs) across HWLH.

It is recognised that many people are unable to attend such events due to work, family and caring commitments. Therefore there is a commitment to ensure that effort is made to try to increase the range and number of the general public participating at C4Y engagement events, partner engagement activities and also to develop other, including 'virtual,' methods of engagement. Healthwatch East Sussex have offered their support in achieving this.

## 3.2 NHS Five Year Forward View new models of care and accountable care systems - Formation and development of the Multi-speciality Community Provider (MCP) Alliance for the HWLH.

A Multispecialty Community Provider model (MCP) is described as a new type of integrated provider system serving the whole population. It combines the delivery of primary care and community-based health and social care services.

Connecting 4 You (C4Y) is a transformational programme and it has been determined that this is best delivered by the adopting the (MCP) as described in the NHS Five Year Forward View. It is perceived that this will allow the flexibility to both progress the four 'communities of practice' and to develop the best fit model to deliver accountable care across the region and the multiple hospital systems in adjacent areas that serve the HWLH population.

During March 2017 senior representatives from ESCC, SCFT, SPFT and HWLH CCG met to consider the development of the C4Y MCP Alliance and in particular make initial agreements about the form and shape. Given the complex geography across HWLH, not least the fact the area is served by four acute hospital trusts, the decision was made to focus on functional delivery ahead of organisational form but to initially adopt a 'virtual' MCP Alliance model.

Membership has been widened to now include;

- The Third and Voluntary Sector (represented via Speak Up)
- Lewes and Wealden District Councils
- Healthwatch East Sussex

It was agreed that a focus on 'frailty' should be the priority for 2017-18 across HWLH. Not only is this identified as a cross cutting priority for all of the organisations represented it was also seen as an ideal opportunity to develop the new ways of integrated working including the formation of the four communities of practices within HWLH which in turn would help determine the optimum alliance configuration for an HWLH accountable care system or MCP.

During 2018 the initial 'virtual' MCP Alliance arrangements will be reviewed with a view to determining the best form for more formal arrangements.

### 3.3 Sustainable Transformation Partnership (STP) and the Central Sussex Alliance

Increasingly CCGs within STP regions across the country are working more closely together on particular issues where it makes sense to do so at a larger scale. It is recognised that by streamlining processes, CCGs can work more efficiently and effectively that helps avoid duplication and ensures there is more consistency in services and quality across a larger area.

Within the Sussex and East Surrey STP, four CCGs – High Weald Lewes Havens (HWLH), Brighton and Hove, Crawley and Horsham and Mid Sussex – have agreed to work closer together in the form of the NHS Central Sussex Commissioning Alliance.

The Alliance will be organised into two places – North covering Crawley and Horsham and Mid Sussex CCGs; and the South covering HWLH and Brighton and Hove CCGs.

There are no plans to merge CCGs as this would require a change of law given they are statutory bodies and the Governing Bodies of each organisation will remain responsible for commissioning healthcare for their local populations.

The Alliance will look at ways in which it makes more sense to do things at a larger scale. For example:

- Performance management of the large cross boarder contracts such as those with the acute hospital trusts
- commissioning pathways for urgent care
- Specialist secondary care services such as stroke and cancer care.
- IT, finance and 'back office' functions

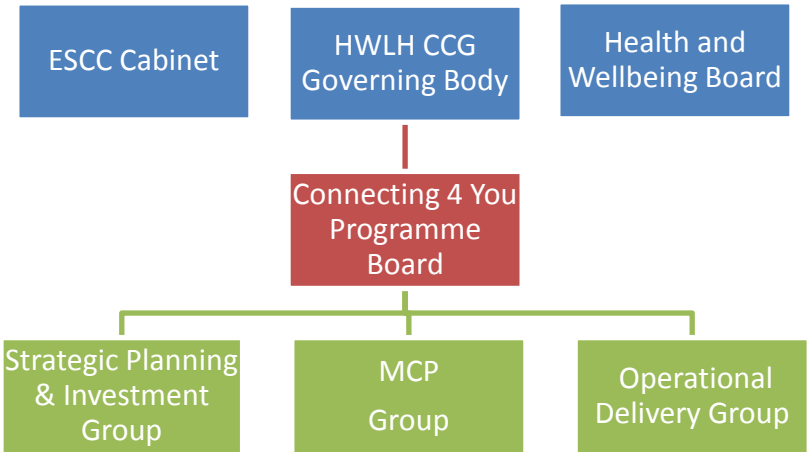
It is important to highlight that this does not change the focus or importance of the Connecting 4 You programme and its shared population as there is still a clear need to transform services and develop better ways of working together on a local or 'Community of Practice' level. To accelerate this work a series of localised 'co-design' workshops are being arranged for November and December 2017 and ESCC Public Health colleagues have offered valuable help in planning and delivering these.

## 3.4 Governance arrangements

The governance arrangements for the C4Y programme are now firmly in place and the sub-groups fully operational with membership that spans the Connecting 4 You partnership.

The three C4Y sub-committees report into and are accountable to the C4Y Programme Board which is the over-arching governance body for the C4Y Programme and its members are all senior representatives from the partner organisations. This includes representation from the third sector as well as Healthwatch East Sussex. It is here that key decisions fed up from the sub-committees are ratified as well as the focus on the mitigation of key exceptions and significant blockages to the programme.

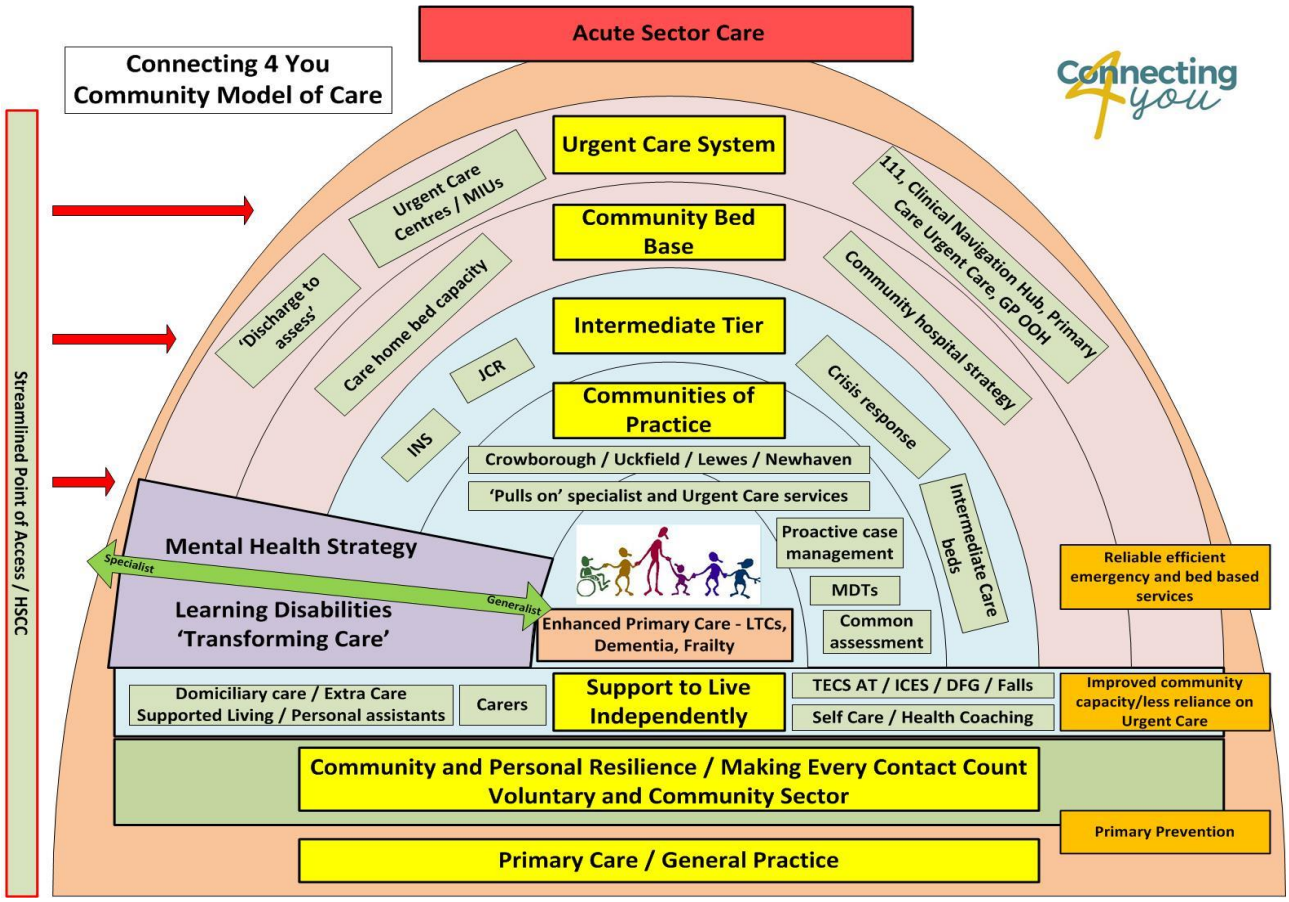
The C4Y governance structure is depicted below;




### 3.5 C4Y Programme Plan

Considerable work has been undertaken to develop the C4Y Programme plan, building on key East Sussex wide enabling developments such as Health and Social Care Connect and then determining the means to deliver effective integrated heath and social care to the population of HWLH working with the different hospital systems that cover this area.

The plan details all of the transformation projects across C4Y partner organisations that make up the C4Y Programme plan over the next 3-5 years. These are grouped into categories that align to the C4Y Community Model of Care as depicted by the diagram below. The yellow boxes in the model describe the fundamental building blocks of the integrated health and social care system for HWLH.




The plan presents comprehensive detail, including risks relating to each project, that is updated on a monthly basis. Attainment of each project to the plan is set around six universal gateways that all require target completion dates.

This is jointly owned plan for the C4Y partners who all have opportunity to identify key transformational initiatives to add to the programme plan as well as contribute to the delivery of planned programme activities.

The C4Y partnership, the programme and associated governance is the means by which the planning and application of the Better Care Fund and Improved Better Care Fund for HWLH are developed, agreed and monitored.

The C4Y Operational Delivery Group manages the programme through comprehensive monitoring that highlights;

- Attainment or slippage in regards to all six gateways for each project included in the plan
- A summary of all risks threatening the attainment of milestones
- Highlight Reports that provide detail of each project.

The following sections of this report highlight a number of key areas of focus and development of integrated working to improve services for the people of HWLH.

## 4. Urgent Care and Readiness for Winter Pressures

### 4.1 Background

Patients access urgent care services when they feel they cannot wait for a GP appointment and need to be seen without delay. Perhaps the most common perception of an urgent care service is the hospital Emergency Department (ED). However patient needs can often met more appropriately, and quickly, in other parts of the urgent care system. It is clear that patients can find the current array of options at times confusing and inconsistent across health and social care systems, and as such default to the ED. The C4Y urgent care programme will offer an integrated urgent care system with a single point of entry via NHS 111 as a viable alternative to presenting at A&E or dialling 999 when it is not an emergency. This model will offer a range of options to the public, including standardised Urgent Treatment Centres, urgent primary care in and out of hours, and other community services, as well as high quality Emergency Departments, whichever service is most appropriate for them.

### 4.2 The Planning Context

As the majority of HWLH inpatients are placed in acute hospitals outside the county (see table 1), the C4Y partnership includes representation from Brighton and Sussex University Hospitals NHS Trust (BSUH); and Maidstone and Tunbridge Wells NHS Trust (MTW), as well as Sussex Community NHS Foundation Trust (SCFT) who hold the contract for community services (including the three community hospitals) with the CCG area

**Table 1: 12 month's inpatient activity up to August 2017**

**12 months inpatient activity up to August 2017**

| | | BSUH | MTW | ESHT | Total |
|---|---|---|---|---|---|
| Eastbourne, Hailsham and Seaford (EHS) | No. | 3,218 | 271 | 45,932 | 49,421 |
| | % | 6.51% | 0.55% | 92.94% | |
| Hastings and Rother (H&R) | No. | 1,365 | 589 | 44,317 | 46,271 |
| | % | 2.95% | 1.27% | 95.78% | |
| HWLH | No. | 15,442 | 10,702 | 5,502 | 31,646 |
| | % | 48.80% | 33.82% | 17.39% | |
| **East Sussex Total** | **No.** | **20,025** | **11,562** | **95,751** | **127,338** |
| | **%** | **15.73%** | **9.08%** | **75.19%** | |

This marked difference is even more noticeable with Emergency Department attendance, as seen in table 2.

**Table 2: 12 months A&E activity up to August 2017**

**12 months A&E activity up to August 2017**

| | | BSUH | MTW | ESHT | Total |
|---|---|---|---|---|---|
| EHS | No. | 3,260 | 186* | 49,745 | 53,005 |
| | % | 6.13% | 0.35% | 93.52% | |
| H & R | No. | 593 | 633 | 50,076 | 51,302 |
| | % | 1.16% | 1.23% | 97.61% | |
| HWLH | No. | 21,352 | 8,870 | 4,585 | 34,807 |
| | % | 61.34% | 25.48% | 13.17% | |
| **East Sussex Total** | **No.** | **25,205** | **9,503** | **104,406** | **139,114** |
| | **%** | **18.12%** | **6.83%** | **75.05%** | |

* Includes one set of suppressed numbers so could be up to an additional 4 patients here

As a result, the CCG, and C4Y partners including ESCC Adult Social Care, SCFT, and SPFT actively feature in the planning and delivery of three systems: East Sussex Healthcare NHS Trust (ESHT); BSUH; and MTW; as well as the STP-wide NHS 111 programme board and Urgent and Emergency Care Network (chaired by the CCG chair, Dr Elizabeth Gill). Through these Boards, comprised of Executive officers from each health and social care organisation, plans have been put in place to ensure urgent care services meet the needs of patients, particularly during the build up to, and during, the Christmas and winter periods. Input form SCFT and SPFT, who span a number of health and social care systems, ensures a consistent response to the planning and delivery of multiagency services. Specific pieces of work are as follows

## 4.3 C4Y Urgent Care programme

### 4.3.1 Primary Care steaming at the Emergency Department front door.

Using local data, up to a third of patients attending Emergency Departments (EDs) in Sussex could be more appropriately, and swiftly, seen by a GP. This is in line with national projections. This year, as part of the Five Year Forward View, all CCGs and Acute Hospitals with EDs were asked to put in place streaming at the front door to steer appropriate patients towards a primary care physician. This will: reduce the pressure upon the ED; reduce the need for a wider array of diagnostic tests; reduce costs due to a lower PBR tariff; and, most importantly, direct patients to the most appropriate care for their needs. Recognising that a significant number of people from HWLH attend the Royal Sussex County Hospital (RSCH) in Brighton and Princess Royal Hospital (PRH) in Haywards Heath, both part of BSUH, the CCG led on the planning and delivery of this service, which went live on 31 October. Through membership of the ESHT and MTW boards, the CCG also received assurance that similar streaming is in place in those hospitals attended by HWLH patients.

### 4.3.2 Delayed Transfer of Care (DTOCs) reduction

Over the last 12 months DTOCs have risen significantly across the country, and this has been particularly felt in BSUH and ESHT. Most noticeably, data showed that East Sussex had a greater proportion of DTOCs relative to other CCGs in BSUH. East Sussex patients were more likely to experience delays to discharge than their counterparts in Brighton and West Sussex. Over the summer the CCG worked with Adult Social Care and SCFT through the C4Y programme to put in place a programme of activity to reduce DTOCs. At the time of drafting, there are 6 patients experiencing delays of an average 7 days, which is down from a high of 27 patients in September with and average delay of 28 days. This has led to an additional focus on delays in the community hospitals, with similar reductions.

### 4.3.3 Admission Avoidance/Discharge to Assess

During the DTOC programme, it became clear that a number of delays were due to patients who, though medically ready, were not leaving hospital because they were awaiting further assessments, for example for Occupational Therapy, Continuing Health Care, or further social services intervention. The CCG has been working with Adult Social Care, SCFT and the Joint Community Rehabilitation (JCR) teams to develop a Discharge to Assess programme which will support patients in their homes, ensuring they spend as little time in hospital as possible and are assessed in their regular surroundings (which research suggest results in them ultimately needing a reduced package of care) and can be managed by the multi-agency Communities of Practice, which were established as part of the new community services contract with SCFT, which went live in November 2015. A full business case will go to the C4Y programme board in December, and subject to approval mobilisation will take place in January 2018.

### 4.3.4 Let's Get You Home campaign

A number of discharges are delayed due to patients and/or their families taking time to accept a package of care, or care home option, made available to them. As well as reducing flow in the acute hospital, this also impacts on patient safety, as research has shown the longer patients stay in acute settings when medically ready to leave, the longer their convalescence is likely to take. Recognising that this can be a difficult time for patients and their carer, the CCG led on a Sussex-wide policy and information campaign for staff, patients and carers to reduce these delays. This was successfully run at the start of 2017, and is currently being repeated across Sussex in time for Winter 2017/18.

### 4.3.5 Enhanced Health Care in Nursing Homes

During the year, and particularly in winter, EDs see a significant number of conveyances from Care Homes. Last winter the CCG piloted an initiative with a number of nursing homes which included 'ward rounds' from local GPs and the creation of agreed care plans which could be accessed by the GP Out of Hours Service in the event of the resident displaying concerning symptoms. The evaluation showed 35 fewer conveyances to hospital over the Christmas period than the previous year. Therefore the CCG is now rolling out an enhanced programme, including training for care home staff and medication reviews, to all care homes in HWLH by April 2018.

### 4.3.6 Community Geriatricians

This is an initiative that commenced in the Havens and was immediately well received whilst showing a clear link to a reduction in non-elective admissions to acute hospitals. community geriatricians are patient facing and provide expert advice to GPs, community hospitals and care homes as to how best to treat and support those living with moderate to severe frailty and have complex co-morbidities. The community geriatricians are employed by the acute hospital trusts serving HWLH hence offering a vital link between these and community services.

This service has now been expanded to the rest of HWLH and has been enhanced further by the support of community pharmacists who can carry out poly-pharmacy reviews to ensure that complex medication regimes are not increasing the risk of a person falling.

### 4.3.7 Winter resilience

As every year, the CCG and ESCC have contributed to the planning for winter in all three health and social care systems which they face. These plans have been subjected to desktop testing facilitated by NHS England, and will ensure that HWLH patients receive the best possible response regardless of which system they access treatment and care from. The C4Y programme has provided a vehicle for community and primary health and social care services in HWLH to engage with acute providers and the voluntary sector to ensure this consistent response.

### 4.3.8 Next steps

During 2017/18 the Connecting 4 You programme will continue to develop an urgent care programme which meets the needs of residents. C4Y Shaping Health and Social Care events, regular contact with Patient Participation Groups, online surveys, and the involvement of patients and carers in project design and implementation are all ways in which patients and public are involved in this programme of work.

## 5. The Dementia Golden Ticket – An award-winning new model of care

### 5.1 Context

A diagnosis of Dementia can be devastating and can severely affect families, relationships and the quality of life, which they all experience. There are expected to be 2,620 people of all ages living with dementia in High Weald Lewes Havens (HWLH) and approximately a quarter of hospital beds are occupied by someone who has a dementia. The total cost of the disease is higher than the cost of cancer, strokes and heart disease combined.

As with other diseases, it makes a difference if dementia can be identified and treated as early as possible. Evidence also proves that a psycho-social model of support can help people with a diagnosis (and their families) to live as well as possible with the condition; this is why the Department of Health's National Dementia Strategy was titled 'Living Well'.

### 5.2 The Case for Change

Local clinical enquiry, including a Quality Impact Assessment undertaken, indicated that the existing HWLH dementia pathway fell short of meeting the needs of patients and carers and did not provide adequate support or quality of care. This cumulative picture was leading to dementia patients presenting in acute and emergency settings, in what was considered to be an avoidable poor state of health. As such, the system was viewed as ill-equipped to support patients and carers with a dementia.

Based on these findings, the CCG engaged in an extensive clinical review and stakeholder engagement exercise. It formalized a partnership with Sussex Partnership NHS Foundation Trust (SPFT), Primary Care, Community Services and the Voluntary Sector and established a clinically-led committee to support the co-production of The Dementia Golden Ticket model of care. This wholly new approach to dementia care and support, involved an extensive re-design of dementia care across the system, with a focus on integrated and holistic care (of both the person with dementia and their family carer) and a shift from Secondary Care interventions to pro-active Primary Care management and post-diagnostic support. It also included a range of psycho-social interventions to help people live as well as possible, for as long as possible with the condition.

Having successfully piloted the model of care at Buxted Medical Centre, the CCG was able to demonstrate with some assurance, compelling evidence that The Dementia Golden Ticket approach improves outcomes for patients and carers, delivers economic benefits to the health and social care system and is preferred by the workforce, to the historical dementia pathway.

Externally, it has been commended as a model of best practice, winning a number of awards and interest continues to grow about its applicability at scale, including nationally.

## 5.3 Implementation and Mobilisation

Further work and refinement, together with the completion of a Primary Care Education package in partnership with Brighton and Sussex Medical School (BSMS), now sees the partnership framework in a state of mobilisation to roll-out the model of care in a phased approach based on 'Waves' of implementation in Primary and Community Care. There is a 2 year incremental model of delivery in Secondary Care due to workforce implications. This approach was approved by the CCG's Governing Body as the most supportive method of rolling out a new model of care and the safest means of managing the transfer of patients from Secondary to Primary Care.

As of the 02 October 2017, 5 Practices went live with The Dementia Golden Ticket with Wave 2 launching in January 2018 (an additional 3 Practices), with plans for another 5 to roll-out from April 2018. The remainder will come on stream, quarterly thereafter.

## 5.4 What's already different and in place in The Dementia Golden Ticket model of Care:

- A new GP referral pathway, making it easier and more streamlined to refer to Secondary specialist services.

- A new Memory Assessment and Management Service undertaking comprehensive assessments and diagnosis in peoples' own homes (SPFT)

- A Dementia Guide Service, providing contact within 2 days after diagnosis, face to face contact within 10 days and on-going practical and emotional support to the person and family living with dementia. (East Sussex County Council Carers Engagement and Respite Service)

- GP surgeries (signed up to the Locally Commissioned Service) delivering post-diagnosis review within 10 days of diagnosis, 6/12 review meetings and weekly, proactive 'Blip' Clinics. All appointments under the framework are up to 40 minutes long.

- Advanced Care Planning documents have been developed for The Golden Ticket model of care and are mandated to be completed by the GP Practice and Dementia Guide Service, within 6 months' of diagnosis.

- 7 weekly Memory Wellbeing Cafes in Ringmer, Buxted, Crowborough, Peacehaven, Ticehurst, Newick and Uckfield. (Know Dementia)

- 3 Leisure Centres providing weekly Dementia Exercises Classes in Peacehaven, Lewes and Uckfield, rising to 4 in January 2018, to include Crowborough. (Freedom and Wave Leisure)

- 3 Weekly Musical Activity Sessions, in Lewes, Uckfield and Newhaven, rising to 5 localities in 2018. (Know Dementia)

- Free Transport for those people that need it, to access community interventions coordinated by the ESCC Transport Hub.

- 2 hour daily 'Hotline' from Primary to Secondary Care for direct and timely support of the Primary Care workforce. (SPFT)

- 2 half day Education Package delivered in partnership with BSMS, to enable identification of a Lead Primary Care Practitioner and GP for every practice rolling out The Dementia Golden Ticket. Next education package to support Wave 3 scheduled for January and March 2018.

### 5.5 What benefit is this new approach and support providing to people and the health and social care system:

**Patient and carer benefit**

- Additional time allocated to this patient group (with appropriate multi-agency support) will help to deliver an enhanced quality of service.
- A shift from acute provision to community-based care, closer to home.
- A model of care which meets the holistic needs of the family situation; improving quality of life, independence and patient and carer experience.
- Patients and carers access good quality and timely information, advice and support, which enable them to self-manage the condition, for as long as possible.
- Carers will receive support, as well as equal access to psycho-social interventions, which enables them to continue in their caring role, for as long as possible.
- Advance Care Planning will be the norm instead of the exception; resulting in improved condition management, and patients and carers having their wishes and preferences respected.
- Practices know their patients (and their families) best and are therefore best-placed to manage their condition.
- Self-reported improvement in patient and carer wellbeing.
- Reduced carer crisis leading to inappropriate admissions to care settings.

**Primary Care benefit**

- A Primary Care Practitioner-led service, which would previously have relied on GP appointments, will release GP capacity to see more non-dementia patients. This contributes to Primary Care sustainability in the longer term.
- Meeting the holistic needs of the patient and carer will reduce overall GP consultation time and release capacity back into the practice.
- Practices will have the capability to treat all physical health problems 'through the lens of dementia' and to manage the patients' needs holistically.
- Primary Care staff (and other inter-disciplinary workers) feel equipped and empowered to manage slow declining dementia in the community.
- The system will re-orient from reactive crisis response to planned and proactive care; which will enable practices to re-organise the way they see patients and assist with overall resource management.

**Secondary Care benefit**

- Secondary Care resources are aligned to the most specialist and complex case-work; with additional capacity aligned to support Primary Care in a timely and responsive way.
- The new Memory Assessment and Management Service will provide a higher quality comprehensive assessment in peoples' own homes, delivering the diagnosis in the best possible way, e.g. in people's own homes.
- The multi-disciplinary specialist team will meet twice weekly, to proactively manage and support the most complex cases.
- The system will re-orient from reactive crisis response to proactive care, which will assist with overall resource management.

**System benefit**

- Primary Care Review and 'Blip' clinics, utilising the 'eyes and ears' of the community and support circle, will maximise opportunities for preventing deterioration and crisis, and thereby reduce admittance to inappropriate care settings.
- There will be a wider spread of dementia knowledge and awareness.
- Easy accessibility to patient information and ability to share information electronically as part of the integrated team.
- Clarity of roles and responsibilities across multi-agencies in the dementia care pathway will prevent patients and carers 'falling through the gaps' and being 'funnelled' through a system of inappropriate and costly care. This should improve patient and carer experience.
- Patients, carers, and health and social care professionals know where to go and who to contact when the person with dementia and/or carer gets into difficulty. This heightened awareness will result in a proactive, integrated and timely response from services, which will help to avoid crisis and admittance to inappropriate care settings.
- Reduced District General Hospital (DGH) admissions.
- Reduced acute dementia bed admissions.
- Reduced carer crisis leading to inappropriate admissions to care settings.
- Delaying/reducing care home usages (based on standardised national evidence base for earlier intervention). An increase in discharges back to original place of residence.
- In year 1 there is a total anticipated system benefit of £74k, rising to £929k in year 2 and £1,452k in year 3. Not all of this benefit is immediately cash releasing.

## 5.6 Governance and Partnership

Oversight of implementation of The Dementia Golden Ticket model of care across HWLH is by an Executive Steering Group for Dementia and a Joint SPFT Implementation Steering Group and progress is reported to the C4Y Programme Board.

As ambitions to recruit Admiral Nurses (specialist Nurses of Carers of people living with Dementia) progresses, a partnership Steering Group including multiple Agencies, (including the Voluntary Sector), will be developed.

## 5.7 Awards

The Dementia Golden Ticket model of care has won the following accolades:

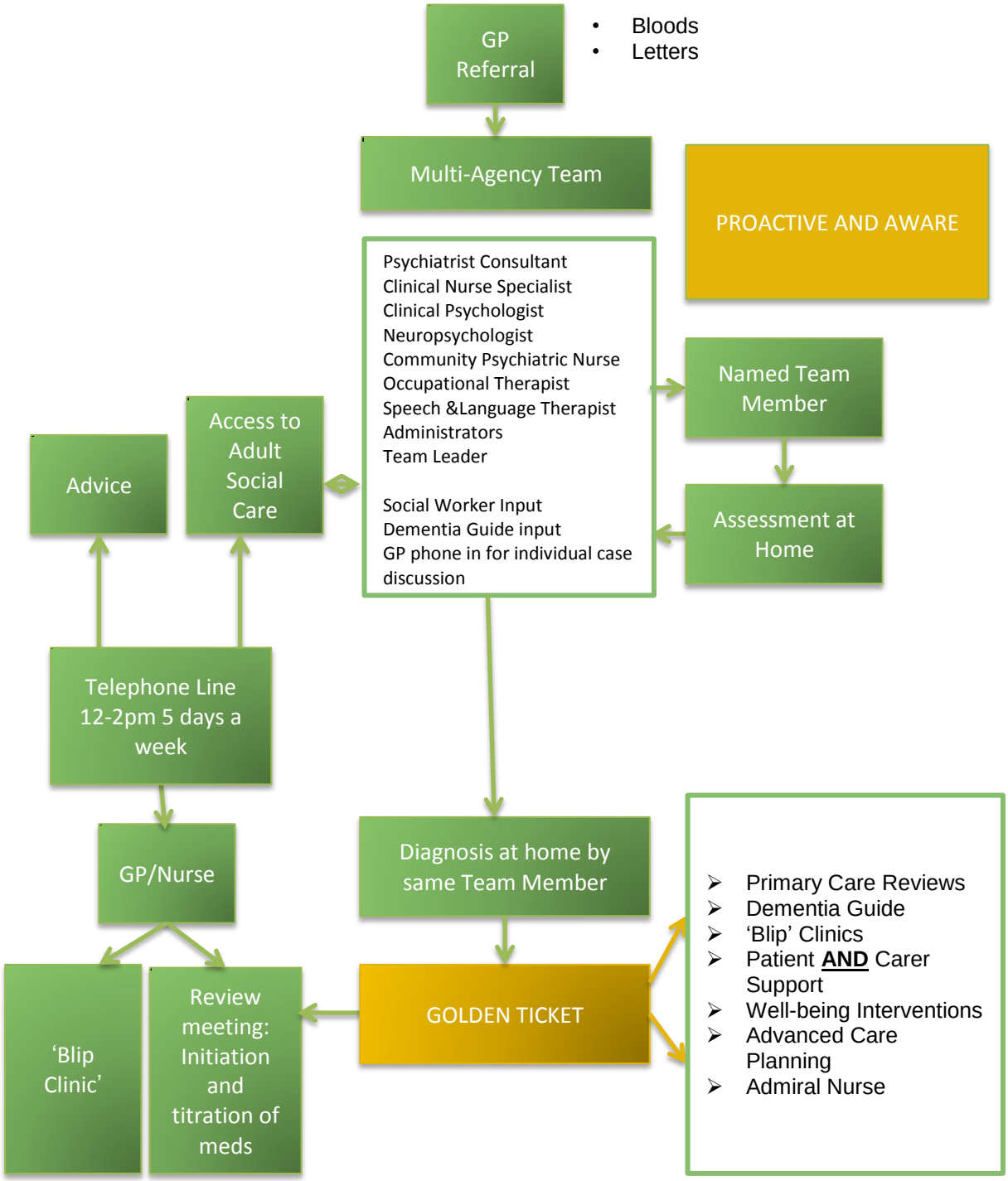
- The National Primary Care Awards 2016 - Winners of 'Pathway Innovation of the Year Award'

- National Dementia Care Awards 2016 - Shortlisted in top 5 for 'Outstanding Dementia Care Innovation'

- The Dementia Golden Ticket Pilot won Gold in the Sussex Partnership NHS Foundation Trust 'Partnership in Practice', award for effective partnership working across groups, within an integrated team, with patients and carers, other teams and organisations. It also won Silver in the 'Team' Category.
- The Dementia Golden Ticket won the Health Foundation's Innovation for Improvement Programme Award.

It is currently Shortlisted in the Primary Care Team category of The BMJ Awards (22 November 2017) and GP Awards (30 November 2017) for Primary Care innovation. The Dementia Golden Ticket has been showcased nationally and internationally, as a model of best practice.

## 5.8 The Dementia Golden Ticket – Full Model of Care



## 6. Lewes Health Hub and Lewes Primary Care Home: Premises and Care Model

Central to the C4Y Programme are the four 'Communities of Practice' (CoP); Crowborough, Uckfield, Lewes and the Havens. These are seen as the foundation for transforming integrated community care in HWLH, serving populations of 30,000 – 50,000. CoPs were a key component of the reprocurement of community services now provided by SCFT. CoPs bring together primary care, community services, ASC, SPFT and the third and voluntary sector. Lewes practices are at the forefront of developing this integrated way of working and are part of a national vanguard programme that describes this as 'Primary Care Home'.

### 6.1 Lewes Health Hub

In December 2014, NHS England announced the availability of £1bn over four years to improve access and the range of services available in primary care, through investment in premises, technology, the workforce and support for working at scale across practices.

Clinical Commissioning Groups (CCGs) were invited to submit recommendations to NHS England to support the funding of improvements and developments in practices.

The recommendations were required to demonstrate the following:-

- Increased capacity for primary care services out of hospital
- Commitment to a wider range of services to reduce unplanned admissions to hospital
- Improving seven day access to effective care
- Increased training capacity

An application from the three Lewes practices to create the 'Lewes Health Hub' was approved by the CCG, and submitted to NHS England on 30th June 2016. On 28th October 2016 confirmation of the success of bid was received.

The proposal is for the relocation of three Lewes GP practices from their existing, challenged premises, into a purpose-built health campus on the North Quarter Development in Lewes. In addition to the new practice premises, the accessible location will provide a catalyst for change to health and social care provision for the town of Lewes.

Integration of the three practices and community services will enable more flexible seven-day working, increase resilience, and enable the patients of Lewes to access a broader range of services within a core mandated primary care services, and enable the use of practice pharmacist, paramedic and nurse specialists working at scale. In addition, the close working will be engendered with ease of access to the associated facilities providing community, social and third sector services that will be situated within the wider health campus, providing more joined up care for the patients within Lewes.

The North Quarter development is being undertaken by Lewes District Council in partnership with Santon, the premises development arm of a South African Pension Company. The development is to be carried out in three phases, with the Health Hub being part of the first phase which is currently projected to be completed by March 2019.

It is envisaged that additional space within the primary care facility will enable the practices to extend the current training programmes and increase from 4 GP trainees with additional medical school and nurse training. Paramedic practitioner training, practice nurse training and physician assistants will also be included within the training programmes.

## 6.2 Lewes Primary Care Home

Following a thorough consultation process of all GPs of River Lodge, St Andrews and School Hill there has been a unanimous agreement to proceed to a merger of all 3 practices.

The three practices seek to shape their Clinical Model on 'Primary Care Home', a model that brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

Within this model staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes. Primary Care Home shares some of the features of the multispecialty community provider (MCP) - its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

This focus will drive locally owned, bottom up change that is sustainable beyond the end of the New Model of Care (NCM) programme in 2017/18, making the programme value for money and truly transformational.

The scheme has been accepted as one of the second wave of 'Primary Care Home' sites supported by the National Association of Primary Care (NAPC) to develop a model of integrated care aligned with a multispecialty community provider as described in the NHS 5 Year Forward View.

Evolving general practice in this way will allow a focus on patient's needs to give individualized care and integrate with other providers of care and well-being in the wider local health community to provide a single point of access for health and social care needs whilst continuing to retain the long-term continuity that patients have come to appreciate in Lewes by working in care teams which will focus on specific cohorts of patients.

Multidisciplinary teams will focus on patient groups with different care needs supported by patient advisors who are able to direct patients to the most appropriate pathway and patient navigators who are able to provide advice and support.

**Patient Groups**

- Children & Young People
- Working Age Adults
- Older People

**Care Needs**

- Complex Needs
- Long Term Conditions
- Generally Well

**Types of care**

- Ongoing Care
- Elective Care
- Urgent Care

### Continuous care teams

By creating small groups of GPs supported by patient navigators these teams will retain the long-term continuity that patients value at the same time as giving daily access for patients with ongoing needs. More complex needs can be helped by proactive case management.

### Acute team

Integrating existing acute care in general practice with minor injuries and minor ailments services. This team can triage patients to the most appropriate member of staff utilising Nurse Practitioner, Paramedic and GP roles.

### Multiagency Team

Complex patients requiring specialist case management are supported by dedicated case managers. Multidisciplinary teams including community nurses, palliative nurse specialists, community psychiatric nurse, social worker, Occupational therapy, community physiotherapy and GP's meet to provide a holistic integrated approach to ensure health and social care needs are met.

### Long-term condition team

'One stop shop' aimed at seeing patients for all routine medication and chronic disease reviews at one appointment. Routine blood testing and blood pressure monitoring with support from specialist nurses and community pharmacists to provide expert advice on long term conditions.

### Nursing Team

Providing an integrated approach to patients requiring nursing care both in the practice and in the community. Bringing together existing separate teams to provide a co-ordinated approach.

### Specialist teams

Patients can be provided with advice when specialist input is required providing services not part of the GMS contract such as travel advice, vaccinations, contraception with coils and implants, sexual Health, dermatology and substance misuse. Over time these can be extended and integrate secondary care roles into the organisation

Redesigning the delivery of acute, chronic and preventive health care and integrating it more closely with the parallel process of social care, community well-being, public health and secondary care will create a truly transformed and sustainable landscape. This aligns fully with the five year forward view to enable a growing and aging population to maximise their health and well-being.

## 7. Next Steps

Presented above are three key work streams that are fully transformational and demonstrating tangible benefits to the health and social care system for the people of HWLH, to offer assurance that the C4Y Programme is active and demonstrating success.

There is full recognition that we are facing economic challenges that are far more stark than those health and social care have faced over the last ten years. Through the C4Y governance forums there is a strong and continual focus on what transformational initiatives need to be implemented as quickly as possible to offer swift and real mitigation in regards to the current pressures throughout the system.

Below is an outline of some of the further transformational initiatives that are actively being developed. All of them have a clear focus on reducing the number of people admitted to acute hospital and better outcomes for the individual.

- Falls; there is currently a scoping exercise underway to identify the gaps in interventions that help prevent falls and also one that help ensure the maximum possible reablement for those that have fallen.
- East Sussex Fire and Rescue Service Home Safety Checks; following the successful initiation in the Havens this service is being expanded into the Crowborough area. This is targeted at those living with frailty and the focus is to mitigate trip hazards and other aspects of a person's home environment that could put them at risk.
- Hospice in the Weald training scheme; This is offered to Care Home staff to better manage end of life care in residential settings thus greatly reducing the number of people who are admitted to die in an acute hospital.

- Integrated Support Solutions; This is an initiative being led by ESCC and aims to bring together a range of currently 'stand-alone' interventions that are all focused on keeping people living independently at home for as long as possible resulting in far more holistic single assessment of a person's needs. This has strong potential to add synergy to the range of interventions being developed to help better support those living with frailty in the community.
- 111/Out of Hours procurement. This is a Sussex wide procurement, which has been the subject of a previous presentation to the HOSC. The local response to the 111 programme will be developed by C4Y, whether in or out of hours.
- The further development of Minor Injuries Units and their alignment with services HWLH patients access outside of East Sussex, including Walk-in Centres, Urgent Care Centres, and EDs. The HWLH MIUs, provided by SCFT, are important clinical assets used by the patient population. As part of the C4Y programme the MIUs will be supported to increase the activity they see and to integrate more fully with primary care both in and out of hours.
- Frailty pathways. HWLH patients currently benefit from a community geriatrician service working with BSUH and MTW. This will be developed in conjunction with the Communities of Practice to ensure a full programme of support to the frail elderly across the CCG area.

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