Appendix 2

Summary of transformation programmes and projects for Urgent Care, Planned Care and Community

Background

The initial transformation programme for 2019/20 recognises our system's need to continue to progress financial recovery, and currently consists of the recommended immediate priority areas of transformation needed to support this. This is taking place in the context of our longer term objectives to improve health, improve the experience and quality of care and improve the overall sustainability of health and social care services - delivering financial recovery will contribute to delivering these broader objectives.

This is based on system diagnostic work on the drivers of our East Sussex system deficit undertaken by NHSE and NHSI and others, such as Carnall Farrar and PwC, as part of the financial recovery process in 2018/19. The evidence base for these priorities is informed by benchmarking tools including Model Hospital, Get it Right First Time (GIRFT) and NHS Right Care, as well as consideration of national and international guidelines, good practice and new models of care.

It should be noted that each of the programmes are at different stages of programme definition and work up, and include some projects that were initiated in 2018/19 as well as projects that are in the very early stages of scoping and development. We will also continue to monitor and develop our established projects, initiatives and services as well as new projects outlined below. As these developments evolve, we will continue to seek the involvement of local people and our stakeholders, to ensure care is built around our residents and their experiences.

There are strong links between all three programmes and many of the changes implemented in one programme will have benefits for other areas. For example work under the community programme aimed at increasing efficiency and capacity in community health and social care services through integration, will enable improved patient flow through hospital and reduced lengths of stay as well as improved outcomes for people and their families. This means benefits across both urgent (unplanned) care and planned (elective) care services will be delivered through the community programme of work.

In summary, the new areas of work to further improve the health and wellbeing of local people right across East Sussex are:

- **Urgent Care:** The programme focuses on avoiding unnecessary hospital admissions through our community service pathways, in partnership with primary care and the South East Coast Ambulance Service (SECAmb), and building on the services already provided in our acute services to make sure that those seeking urgent care are seen by the most appropriate clinician, treated and either admitted or discharged as quickly as possible.
- **Planned care:** we want to make sure that those people who are referred into hospital are seen and treated as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

- **Community care:** we want to further build on the services we provide in people's homes or in the community. We will make sure that there are clearer pathways for people accessing community care and build on the support we provide to people after they leave hospital. We also have plans to further integrate teams of health and care staff across the county, supported by a single leadership structure.

The three programme areas are as follows:

1 Urgent Care

1.1 The key focus of the Urgent Care programme is to transform urgent and emergency care services in East Sussex to ensure that, in an emergency, people are treated in the most appropriate place by the right clinical and/or social care service. The programme focuses on building pathways and capacity within our community and primary care services to reduce to support patients in their own home. The programme is aligned to the community service re-design to enable the outcomes from the programme. It builds on the services already provided in our Emergency Departments, acute medicine and surgical assessment units to make sure that those seeking urgent care are seen by the most appropriate clinician, treated and either admitted or discharged as soon as is appropriate.

1.2 The programme is also closely aligned with work across the Sussex and East Surrey Sustainable Transformation Partnership (STP) area, in the wider context of a delivering a standardised approach to urgent and emergency care pathways across the STP footprint. The projects are a mix of existing work to implement Urgent Treatment Centres and new local priorities identified as a result of financial recovery diagnostic work, in summary:

- Extending Acute Frailty will look to build in the appropriate interventions when people require hospital care to ensure they receive a timely frailty assessment, and support patients to return home or to another appropriate care setting when patients no longer require consultant led care in an acute setting. Subsequent community services will also be aligned on discharge to reduce frailty severity where possible.
- Extending Ambulatory Emergency Care (AEC). AEC is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed, giving the opportunity to better manage patient flow, improve patient experience and reduce acute hospital admissions. AEC is already provided by our hospitals, however, this project looks to increase the availability of AEC to a minimum of 12 hours a day, 7 day a week. This will also help meet requirement in the NHS Long Term Plan to increase treatment and discharge from Emergency Care without an overnight stay.
- Support to care homes is at the exploration stage of looking to understand how appropriate support can be delivered to people in care home settings.
- To address the increased demand on our A&E services, in November 2018 a High Intensity User (HIU) service went live in East Sussex. The HIU service (initially developed by NHS Blackpool) offers a robust way of reducing high unscheduled users of multiple services such as 999, NHS 111, A&E, General Practice and hospital admissions, freeing front line resources to focus on more clients and reduce costs. It uses a health coaching approach, engaging with high users of services whose needs are often unable to be met fully by one area of service. It supports some of the most vulnerable clients within the community to flourish, whilst making the best use of available resources. The service is now fully operational with two key workers visiting

high users of services with very significant improved outcomes evidenced already. In 2019/20, the NHS Operational Planning and Contracting Guidance set out that all health systems in England must implement a High Intensity User service.

- A&E Five Pathways provides the ability for our ambulance staff and GPs to contact our Crisis Response team via our Health and Social Care Connect Service to avoid an unnecessary A&E admission, for five common conditions that result in 999 calls and an unscheduled conveyance to A&E. The five conditions are; Urinary Tract Infections; falling with no injury; Pneumonia or Flu; blocked Catheters, and; Cellulitis. The evidence suggests that putting in place consistent alternative pathways could result in better management and better outcomes for people. The project scope is being expanded in partnership with SECAmb to include further pathways and access by the wider paramedic and technician workforce.
- The Locally Commissioned Service (LCS) for Chronic Respiratory Conditions provided by General Practice has recently commenced, aimed at supporting the better management of respiratory conditions in the community to ensure people are less likely to deteriorate, and reducing emergency admissions. This project looks to measure the outcomes from providing training workshops, regular out of hospital reviews of medication, and medication application techniques.
- Urgent treatment centres (UTCs) are GP-led services that are equipped to diagnose and deal with many of the most common ailments people often attend A&E for. Open at least 12 hours a day, every day, UTCs offer appointments that can be booked through 111 or through a GP referral. This is an existing project as part of the national requirements to implement UTCs and develop a standardised approach to make best use of emergency care resources across our STP. UTCs are intended to ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases. This includes reducing attendance at A&E and, in co-located services, provides the opportunity for streaming at the front door.
- As part of implementing UTCs Walk-In Centres will be reviewed to ensure there is no duplication of services and to maximise the role of out of hospital services that complement the new UTC facilities.

2 Planned Care

2.1 Planned care can be defined as routine services with planned appointments or interventions in hospitals, community settings and GP practices. This is also sometimes known as elective care, and is any treatment that doesn't happen as an emergency and usually involves a prearranged appointment. Most patients are referred for planned care by their GP.

2.2 We want to make sure that those people who are referred into hospital are seen and treated as quickly as possible. There will be quicker routes to tests, enhanced technology to detect any concerns faster and one stop clinics that will bring together consultations, tests, treatment and support in one place, at one time.

2.3 The Planned Care programme brings together a series of projects aimed at reducing variation in planned care referrals and pathways, optimising referrals and evidenced based, clinically effective commissioning to ensure the best patient outcomes and experience. The current focus is supporting more effective patient pathways between primary and acute care,

and future phases will take forward the redesign of Outpatients services. Current projects include:

- Part of an STP-wide programme, clinically effective commissioning (CEC) aims to review and standardise non-emergency treatments and procedures to reduce variation, reduce waste and make best use of limited resources. It will support referrers to use the appropriate guidelines agreed by clinical commissioners to ensure unnecessary high risk interventions are not carried out, as well as manage referrals for procedures that are either not routinely funded, or require patients to meet certain eligibility criteria before they can receive treatment.
- There are a range of projects focused on Cardiology. These include looking to reduce variation in the way community cardiology provides community-based assessments for people who may have problems with their heart, blood pressure or breathing, and standardising the use of procedures such as CT scans and angiograms. This project is looking to standardise pathways across the east and west of the area and so more patients can be treated within the community setting to make best use of capacity.
- In keeping with the NHS LTP requirements East Sussex health organisations are exploring working together to transform Outpatient care. This will range from ensuring appropriate GP referrals through to optimising appointments within the hospital. Digital enablers such as Patient Knows Best and Virtual Fracture Clinics are a couple of areas looking to reduce waste on pathways and reduce patient travelling requirements to improve patient experience and outcomes. The initial focus will be on Ophthalmology, Gynaecology, and Urology.
- Diabetes Pathway Redesign is a project implemented last year and has resulted in successfully avoiding amputations and improving preventative care by providing GP led multidisciplinary community teams as well as greater levels of patient involvement in decision-making and self-care. East Sussex CCGs is now leading on Diabetes pathway re-design across the Sussex and East Surrey STP, to further build on this model and inform an STP-wide approach.
- The Direct Access Ultra Sound - Non-Obstetric Ultra Sound project looks to reduce the number of requests that do not comply with the criteria for an ultra sound as set out by the British Medical Ultrasound Society, to improve waiting times, capacity and patient experience and outcomes.

3 Community

3.1 A summary of the agreed projects and further work for integrated community health and care services, resulting from the financial recovery process was shared at the meeting of the HWB on 23rd April. The work and initiatives carried forward from the ESBT programme will continue, most critically the joint management of community health and social care teams. We want to further build on the services we provide in people's homes or in the community. We will make sure that there are clearer pathways for people accessing services in the community and build on the support we provide to people after they leave hospital.

3.2 Our approach is consistent with the NHS Long Term Plan direction for primary and community healthcare, including the establishment of Primary Care Networks, greater multi-disciplinary working across primary medical care and community health and social care to both support rapid response in a crisis, as well as a local approach to population health management to proactively prevent the escalation of health and care needs.

3.3 Together the linked projects described below make up phase 1 of the programme for 2019/20. They set out a series of pragmatic and realistic steps to be taken over the next 6 – 12 months to progress fuller integration of community health and social care services, with the overall aim of supporting people's independence and long-term care to better manage demand for acute hospital services. In brief the projects include:

- In Eastbourne, nursing and social care teams have come together to trial working from a shared base, to support joint working and the care co-ordination model for people with complex and longer-term support needs. This pilot will guide how joint working works best, and will include engagement with primary care, mental health and voluntary services.
- New 'Home First' pathways are being tested out. These are new, joined up pathways designed to get medically fit people home from hospital sooner, and to make sure that assessments for community support and decisions about longer term care are not made in hospital.
- Joint working between East Sussex County Council and East Sussex Healthcare NHS Trust Occupational Therapy staff will be developed, to share skills, best practice and help create capacity. This is expected to include developing a joint duty and triage service that will simplify and streamline the referral and allocation process.
- Work will also take place to look at the best ways for different teams and services to work together to provide integrated, rapid response, community services to support discharge from hospital and avoid unnecessary hospital admissions. This will be complemented by the continuing development of the Crisis Response service (referenced elsewhere in this summary) which will continue to avoid unnecessary admissions by managing medical crises in the community where appropriate.