Annex: East Sussex - integrated care in communities

Our population health and care needs

In summary, the following characteristics of our population significantly drive our local plans for integrated health and care in our communities:

- Our growing and ageing population - by 2026 almost one in four people (24%) will be aged 65-84, and more than 4% of our population will be over 85. Added to this by 2028, around 20,000 more people in East Sussex will be living with two or more long term health conditions than was the case a decade earlier.

- Increasing numbers of children and young people with Education, Health and Care Plans, some of whom will have complex medical and care needs; and growing levels of need and complexity in relation to safeguarding for children and young people

You can read more about East Sussex, its strengths and challenges and our plans overall in our Health and Wellbeing Board Strategy and the summary in Appendices of the Sussex Integrated Care Strategy.

In response, we have worked together to offer joined up care that can enable more support for complex needs in community settings, across all age groups. For children and young people this has meant:

- An integrated service for 0-5 year olds including health visitors, family keyworkers, communication support workers.
- Multidisciplinary staff teams for youth offending, specialist family service (SWIFT) assessments, young people's substance misuse services, and mental health services for children in care and adopted children.
- An integrated Single Point of Advice and front door joining early help, social care and mental health
- Developing stronger links between mental health and emotional wellbeing services, and enabling access to shared information

With more older people, which includes those who are frail and have multiple conditions, East Sussex is likely to have higher health and care needs than other areas of our size. To help with this we have put in place a model of integrated care aimed at supporting independence, reducing avoidable admissions to hospital and improving discharge into community-based care. This includes:

- Health and Social Care Connect – a single gateway for community health and care queries open to staff and the public and operating 24/7/365
- Joint Community Reablement – a partnership between Adult Social Care and Health providing short term rehabilitation and packages of care in people's own homes after episodes of ill health or time in hospital

- Crisis response team – responding to certain health pathways as an alternative service to hospital
- Discharge to assess – a joint approach to assessing people in short-term beds or their own home rather than hospital
- Integrated health and social care teams – community nursing and social work services aligned and sometimes co-located, with integrated management arrangements and working with local GP surgeries, care homes and home care agencies.

Alongside key voluntary sector and housing services, and support for carers and families, this joined up offer of care contributes to enabling people to live independently and well, for as long as possible in their own homes.

How we'd like to build on this - integrated health, care and wellbeing in our communities

Our next steps as the East Sussex Health and Care Partnership will be to build on these strengths to expand the integrated community model for our population in the following ways:

- Designing and agreeing an approach for working together in our communities across primary care, community healthcare, education, social care, mental health, and the full range of local voluntary and community and housing organisations, driven by a deeper shared understanding of local needs

- Making sure we keep strengthening our offer of integrated care. For children and young people this is about working with whole families (including through the Family Safeguarding model), and linking ever more closely with early years settings, schools and colleges. For adults this includes further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care

- To support improved population health overall and therefore the years of life people spend in good health, we've agreed our model needs to link strongly with the wider services in local areas that impact on social and economic wellbeing as well. This includes leisure, housing and environment services provided by borough and district councils and others.

Our partnership plans to embed hubs in communities to help coordinate access to local sources of support and activities will be a key part of this model, for example to boost emotional wellbeing and help with loneliness and isolation. We also want to develop our plans for using our power as employers and buyers of services to stimulate economic and social wellbeing in our communities. This model will bring:

- Greater capacity in communities to promote mutual support, and deeper levels of joined up and personalised care, building on the strengths and assets of individuals, families and communities
- Greater levels of prevention, early intervention and ways to anticipate health and care needs

- New ways to remove the barriers that prevent staff and volunteers working in different teams from working together on the ground.