East Sussex Better Together (ESBT) Phase One: Summary 150 week closure Report

NHS Hastings and Rother Clinical Commissioning Group
NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
Sussex PArtnership NHS Foundation Trust
East Sussex Healthcare NHS Trust
East Sussex County Council

1. Introduction

East Sussex Better Together (ESBT) phase one consisted of a 150 week whole system health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population. Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes.

At the end of this first phase we are now rapidly moving towards the next phase of ESBT with the establishment of our ESBT Alliance in order to fully realise our ambition of an integrated whole system health and social care system in East Sussex.

The purpose of this closure report therefore is to provide Governing Body members with:

- a high level of review of achievements over the period for each Workstream / ESBT group; and
- information regarding the future governance of each workstream as we move to business as usual.

2. System Alignment

Much of the focus of this report will be on the achievements to date of the different workstreams developed as part of the ESBT programme to change the way health and social care is delivered locally. But, perhaps the biggest achievement of phase one of the programme has been to establish a shared understanding of the issues facing East Sussex and an agreement that a sustainable health and social care system can only be achieved through partnership.

Phase two of ESBT represents the formalisation of this partnership working. Significant progress has already been made on this agenda with each organisation agreeing to formalise arrangements through the establishment of the ESBT Alliance. Integrated governance structures and arrangements are already in place to oversee a test-bed year, **2017/18**, underpinned by an Alliance Agreement. This will create a framework in which different delivery vehicles and partnership models will be evaluated to help determine future governance arrangements and the best organisational structure to deliver the vision of fully integrated health and social care system within a new model of accountable care.

3. Workstreams

The development and implementation of our transformation plans which directly impact on service delivery, and the enabling work streams established to better support integrated working, were overseen and managed via specific ESBT workstreams. A summary of progress and key achievements of each are outlined below.

4. Proactive Care

A number of projects have been developed and delivered as part of this programme of work all of which are aimed at reducing crisis leading to hospital admission and helping to support people living in their own homes. These include:

- We have launched **Health and Social Care Connect (HSCC)** which offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals. Streamlining access frees GPs to see other patients rather than having to refer to several different services for a patient. It also supports faster access to the services for patients in their home. In 2016/17 HSCC supported 119,488 people: c53,000 received information, advice and signposting; and c66,000 received community health and care services; a 14% increase on the previous year of establishment.

- We have also established a **single front door for referrals** for Children's social care and non-statutory early help, linked to Child and Adolescent Mental Health Services (CAMHS), so that referrals to CAMHS can be redirected, where possible without referrers needing to re-refer.

- People receiving care and support from our **Integrated Locality Teams** will have a care coordinator who is the patient's main point of contact and will make arrangements to ensure that the person's changing needs can be met. The new approach will lead to better outcomes for people as well as improved information-sharing and less duplication. By working more closely together, the teams are able to deliver more cohesive and appropriate care and support more quickly.

- **Integrated Duty and Triage Teams (IDATTs)** have been established. Front-line health and social care teams working within community settings have been successfully integrated into single teams across six different localities. In doing so the teams are now better placed to support multidisciplinary working and reduce duplication by directing patients/clients to the most appropriate support first time. Feedback to date from both patients and staff has been positive.

- **Frailty Practitioners** are offering patients frailty specialist assessments and coordinating their care under the guidance of consultants to provide additional support to complex patients, both out in the community and within acute hospitals. In its first six months the service has put in place 115 PEACE plan (agreed life plans). As a direct result **inappropriate hospital admissions amongst this group has reduced by 83% and there has also been a 91% in hospital bed days.** By undertaking a holistic assessment of a person's needs, the team is able to identify, support and improve the quality of life of older people living with frailty in East Sussex. Based on its success and

the ethos of the approach the Care Quality Commission (CQC) is now promoting the use of this model to Care Home managers in Eastbourne.

- A **Proactive Care Practitioner** service has been introduced into each locality. Its role is to identify patients at risk of developing or living with a long term condition (diabetes etc.) and provide support to access services or making lifestyle or self-management adjustments to reduce unnecessary crisis leading to hospital admission. **The service has supported over 300 patients so far and developed close links with 27 GP Practices.**

- A **Crisis Response Team** has been introduced. Its role is to reduce inappropriate presentations and admissions to an acute hospital by providing safe alternatives in a community setting. With a 2 hour response time its role is to provide up to 72 hours of support in a person's own home until either their physical condition improves or a longer term package of support can be put in place. The emphasis is on wrapping individualised care around the patient in a way that meets their specific needs and the feedback about the service that our health professionals have received so far has been very positive.

- **Falls and Fracture Liaison Service.** With our elderly population locally, the risk of people falling in their own home and sustaining injury is comparatively high. The aim of this service is to reduce the risk of falling. It offers a range of services aimed at achieving this including: aids and supports within the home, balance and exercise classes and targeted care home support.

- A fully integrated **Technology Enabled Care Services (TECS)** has been introduced. This has vastly increased the number of people who have received things like personal alarm systems and a proactive telephone checking service which supports independent living, allowing people to remain in their own home.

- We have gained free licenses from NHS England (NHSE) and become part of the national **Patient Activation Measure** programme. We have agreement from 11 services to pilot in phase 1 in **2017**.

- Locality Networks to bring together sectors at a locality level have been established in partnership with the Voluntary and Community Sector (VCS).

- A new Integrated Lifestyle Change service model has been developed and commissioned through full competitive tender process.

- A Making Every Contact Count (MECC) behaviour change brief intervention training approach has been rolled out to East Sussex

Healthcare NHS Trust (ESHT) and the VCS. Over 1000 staff have been trained in 2016/17.

- 183 schools and colleges have whole school health improvement plans and have undertaken sustainable activities to address their priorities.

Most of the projects developed as part of this workstream have now been fully or partially implemented. The priority for **2017/18** is to continue to monitor performance and the activity of each scheme to ensure the benefits are realised and the outcomes delivered.

5. Urgent Care

An integral part of the ESBT Programme has been the review and redesign of our urgent care services. This has been divided into two workstreams which are; Front Door Redesign and NHS 111 Re procurement / Redevelopment of the Clinical Hub. These have involved stakeholders from across the system to ensure all aspects of this complex issue are addressed. These working groups have reported into the Urgent and Emergency Care Programme Board and are now overseen by the Local Accident and Emergency (A&E) Delivery Board. The improvements are outlined below.

5.1. Front Door Redesign

The aim of this piece of work has been to improve patient experience and reduce admissions via A&E. Four key initiatives were supported through this work:

- Extending the Hospital Intervention Team (HIT) to work in the evenings and weekends. This team has been embedded in A&E for a number of years during core working hours. It is comprised of therapists, social workers and district nurses. They work with the clinicians in A&E to discharge complex elderly patients safely, providing support and equipment to avoid readmission. By extending their hours we expect to reduce unnecessary social admissions and improve patient outcomes.

- Establishment of a Take Home and Settle service. This is to work jointly with Hospital Intervention Team (HIT) to transport patients with complex mobility or social needs back to their own homes out of hours.

- Non Clinical Navigators. This newly implemented team support patients to access services or advice, for example setting up a GP appointment. This in turn reduces the time clinical staff need to spend on non-clinical issues.

- Pilot of Co-located GP Streaming. This pilot was undertaken over Easter 2017. This allowed any patients attending A&E with a same day primary care need to be seen within 4 hours. This pilot will inform the future modelling and has demonstrated this can be a useful way of reducing pressure on A&E and preventing unnecessary admissions.

5.2. NHS 111 Reprocurement / Clinical Hub Development

This workstream has been supporting the reprocurement of NHS 111 services across Sussex, which is now being led by Coastal West Sussex CCG. The reprocurement is expected to be complete, with a new service in place, by **April 2019**. Alongside this reprocurement process ESBT has worked with East Sussex County Council (ESCC) Adult Social Care to begin an ambitious development programme to enable HSCC to become the Local Clinical Hub for East Sussex. There is now a milestone plan in place and this is expected to deliver by **October 2018**.

6. Planned Care

This programme has concentrated on developing collaborative approaches with partners in order to strengthen and streamline patient pathways.

A significant education programme focussed on effective change management approaches has been delivered to over 130 patients, doctors, nurses and other professionals from across the health and social care system involved in the pathway redesign work.

To date much of the pathway work has looked at long term conditions (diabetes, respiratory or heart disease). A number of projects are currently being developed that aim that support prevention and the self-management of these diseases by patients to prevent crisis (and hospital admission) as well as improving the integration of primary and secondary care services.

Work is also currently being developed in reducing referral variation and reducing the number of outpatient clinics patients need to attend by finding new innovative ways that mean they do not need to go to a hospital for be told all of the test results were normal, for example.

In addition to the work programme being developed the programme has already delivered:

- Pathway changes in Ophthalmology have meant that patients with minor eye conditions can directly access local optometrists for assessment and treatment rather having to be referred to hospital.

- The pathway for those with symptoms irritable bowel syndrome has been streamlined meaning they no longer need to undergo any invasive procedures.

- Some Ear, Nose and Throat (ENT) patients with minor conditions can be managed within local A&E departments rather than having to travel to regional centres to see a specialist.

7. Mental Health Workstreams

Within the mental health workstream a Transformational Board has been established with membership from all key partners. Its aim is to agree

priorities for transforming services and to work in collaboration to deliver our shared aims. A number of projects have been delivered through this ESBT programme:

For children and young people:

- A new 7 day seven day specialist **Community Eating Disorders Service** in East Sussex for young people has been set up. In addition BEAT, a national eating disorder charity, has been commissioned to support young people, parents and carers through providing training and education and a helpline.

- We have developed an expanded **perinatal mental health multidisciplinary** team across East Sussex, in addition to the Sustainability and Transformation Plan (STP) bid.

- New drop in clinics are being run in GP surgeries across East Sussex provided by the **primary mental health workforce**, providing more direct work and strengthening the links between General Practitioners (GPs) and schools.

- An **online counselling** offer is now available for young people in East Sussex.

- **Paediatric A&E psychiatric liaison** support has been put in place at both acute sites in East Sussex.

- A '**one stop shop'** service arrangement has been put in place in Hastings for young people aged 14-25, bringing together the County Council's Early Help Service, CAMHS, Adult Mental Health Services (AMHS) and local voluntary organisations, with the involvement of young people.

For adults:

- An innovative third sector-provided **social prescribing service** has been introduced to ten GP practices in Hastings, who have welcomed it as highly successful in reducing subsequent consultations by 59%, according to their own data. The service was recognised by the Royal Society for Public Health (RSPH) in November 2015 with an 'Innovation Award' for its work in promoting health and wellbeing.

- Investments have been made into delivering the Crisis Care Concordat by expanding Liaison services and Crisis Resolution and Home Treatment Team (CRHTs), and rolling out Street Triage which has substantially reduced c136 detentions with near zero being taken into police custody.

- New waiting time standards for Improving Access to Psychological Therapies (IAPT) have been delivered, whilst maintaining average recovery rates at above 50% and increasing numbers entering treatment

to 16% and 18% of population prevalence respectively in Hastings and Rother (HR) and Eastbourne, Hailsham and Seaford (EHS) CCGs in 2016/17.

- An intermediate care scheme for dementia patients has been introduced. This provides step-down support following acute in-patient psychiatric care in hospital and supports people remaining in their own homes.

- Recognition has been received for the introduction of our primary care based and provided Memory Assessment Services in the Health Service Journal article: https://www.hsj.co.uk/topics/quality-and-performance/memory-test-showed-value-of-keeping-it-local/7010677.article

8. Medicines Optimisation

The Medicines Optimisation Strategy (2015-18) is a key workstream within the ESBT transformation programme. It has involved clinicians working collaboratively across the health economy to support safe and cost-effective prescribing through our implementation of an East Sussex Health Economy Formulary and other joint medicine policies.

Delivering improvements in the quality of care through **patient-centred medication reviews**, has in turn released significant financial efficiencies. Highlights of particular note are:

- Delivery of a successful pain management review project has gained national recognition and is included as a case study in the NHSE RightCare Long term conditions pack.

- Introduction of a comprehensive medicines optimisation service for care homes providing an annual multidisciplinary medication review for every care homes resident in ESBT.

- Recruitment of a prescribing support dietitian to improve individual support to patients prescribed oral nutrition.

- GP prescribing of antibiotics across ESBT has continued to meet the NHSE Quality Premium targets.

- There has also been a focus on improving the quality of the **repeat prescribing processes**; involving Patient Participation Groups (PPGs) in tackling the issue of medicines waste; increasing the use of more efficient electronic systems and increasing community pharmacist contact with patients to discuss their medicine use.

- Healthy Living Pharmacist (HLP) has been recruited, HLP level 1 roll out is being supported and level 2 roll out is in development. 53 pharmacists and 10 pharmacy staff in wider roles attended leadership training in preparation for new ways of working.

9. Workforce

Recognising that each ESBT partner organisation faced similar issues in being about to recruit staff in sufficient numbers and with the appropriate skills to support changing health and social care models of care, an ESBT workforce workstream was established which has aimed to agree a joined up approach to address workforce planning gaps. A comprehensive system wide workforce strategy has been developed and operational plan agreed, identifying in-year priorities.

Through this collaboration a number of different projects have been delivered:

- The **Community Education Provider Network** (CEPN) has been established. This brings together all those involved in education and training in Primary Care into partnership and has helped to shape workforce plans across each area. A CEPN Operational Plan has been published and progress is monitored via the Operational Group and Delivery Board. Key outcomes have included a range of initiatives to develop non-medical workforce in primary care.

- A leadership development programme for Integrated Locality Team Managers has been designed and commissioned to ensure they have the skills and expertise to successfully integrate teams.

- A system-wide recruitment tracker has been established. This provides assurance that recruitment and staffing issues affecting the delivery of new schemes are being monitored and where appropriate actions are taken.

- A new workforce planning tool (Workforce Repository and Planning Tool – WRaPT) is currently being piloted. This will provide further support to the recruitment tracker model, but will also allowing modelling of the wholesystem on the impact of projects currently being implemented. This will allow us to understand changes in demand in different parts of the system and therefore flag future what changes in demand for staff will be and proactively recruit into those areas.

10. Digital Programme

The aim of this programme is to establish long term Information Technology (IT) solutions across ESBT organisations. This includes:

- How existing technologies can be joined up.
- Determining whether solutions are best sort locally or at an STP level.
- Understanding what new systems can be developed to support integrated working across all sectors.

Whilst much of the work of this workstream has to date been involved in scoping the different systems in place and identifying possible solutions it has delivered a number of benefits already:

- A Governance framework has been established, including creation of ADA (Architectural Design Authority) which has been very successful in providing solutions for some of the practical changes needed to enable joint working. For instance: reciprocal Wi-Fi access has been introduced across all main sites enabling NHS staff to access their network in ESCC sites and ESCC staff to access the council network at NHS sites, including GP surgeries.

- We have supported front line locality team staff in accessing client / patient records (providing NHS staff with access to social care systems - and reciprocal access arrangements for social care and NHS systems).

- We have established joint service desk arrangements for all health and social care staff.

11. Other Supporting Workstreams

Underpinning the delivery of each ESBT workstream have been a number of different functions. Each has had a positive impact on the delivery of projects:

- **Communication and Engagement**. Through health and well-being events and direct contact with stakeholders a comprehensive engagement approach has been vital in both the design of different projects and in their successful delivery.

- **Finance**. Finance underpins everything that is being done to create a sustainable health and social care system locally. The development of the SIP has helped in the monitoring of existing projects. It has also helped to articulate to the system the scale of challenge and in maintaining focus on further delivery. The SIP has also been used widely with regulators to show how much the ESBT programme has made progress in delivering its aims.

- **Commissioning Reform**. Significant work has been undertaken into how services locally can be commissioned, concentrating on outcomes rather than being activity based alone. This work underpins current thinking and will be increasingly used to inform new governance structures within the Accountable Care System.

12. Workstream Governance

All of the projects outlined within this paper that have formed part of the ESBT Programme, have been developed within different workstreams largely separate from each other. Given the scale and complexity of the programme a number of structures were put in place to provide governance and assurance that projects delivered to objectives of ESBT.

As the ESBT Programme comes to an end, responsibility for the health and social care system locally becomes the responsibility of ESBT Alliance

Partnership. Accountability for the development of integrated strategies will be through the ESBT Alliance Governing Board and for the delivery of services through the ESBT Alliance Executive. These new governance structures being established include:

- Planning and Design Groups – These originate from the different ESBT workstreams and are structured around the 6+2 box model, but membership is increased to include representation from all partners. Planning and Design Groups will agree the strategic direction and priorities within each specialist area for the coming one to two years in order to achieve the overarching strategic outcomes framework.

- Integrated Strategic Partnership Group (ISPG). ISPG is a pan-partnership meeting aimed at providing oversight and review of the work or Planning and Design Groups. To ensure individual plans are joined up and positively support each other. This meeting is directly accountable to the Alliance Executive.

- Programme Management Office (PMO) - Successful delivery of integrated solutions will continue to be underpinned by work around back office infrastructure. The precise nature of this structure is currently being developed but will involve bringing together the functionality of the different partner PMO functions.

- Assurance will continue to be supported by a range of financial and activity models including the SIP. These allow us to understand the impact of projects on different parts of the health and social care system, and support the future development of operational plans to meet changing patterns of demand for services.