



NHS



East Sussex
County Council

East Sussex Better Together: Shaping Services for the Future

Feedback Report Shaping health and care Services Events May and June 2015

**We would like to thank all those who came and participated
with such interest and energy.**

For a hard copy version of this report or the presentations from the events please call 01273 485399 (extension 3687) and speak to our Engagement Officer.

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You said, we did:

There to be a consistent named person that people can talk to

As part of the new model of care, people with complex needs will have a named keyworker to co-ordinate their care.

Better links between integrated community teams and community organisations

As we develop the integrated community teams, we will link with community groups and organisations in that area to look at gaps in service and how we can develop more support options

Information sharing to be improved to avoid repetition

We are developing access to shared care plans and documents, so that urgent care professionals can view shared plans (with appropriate patient consent)

More co-ordination between local groups and voluntary organisations to tackle local issues

Your views were in a report presented at the first meeting of a new workstream on how we build healthy communities

ESBT presentation easier to follow and understand

We have published a simplified video with BSL signing and subtitles, making it easier to follow and understand

Introduction

The three clinical commissioning groups (CCGs) in East Sussex (Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Havens CCG) have been holding twice-yearly Shaping Health workshops with local people since their formation in April 2013.

In 2014, we launched ***East Sussex Better Together*** with East Sussex County Council. It's our work together to achieve our shared ambition of a fully integrated health and social care system in East Sussex, so we can ensure high quality and affordable care now and for future generations. In keeping with this shared approach, the events are now called ***Shaping health and care***.

One workshop was hosted in each CCG area, together with health and social care staff. As well as focusing on the achievements and challenges for that area, the three workshops followed a common format and shared the East Sussex Better Together theme.

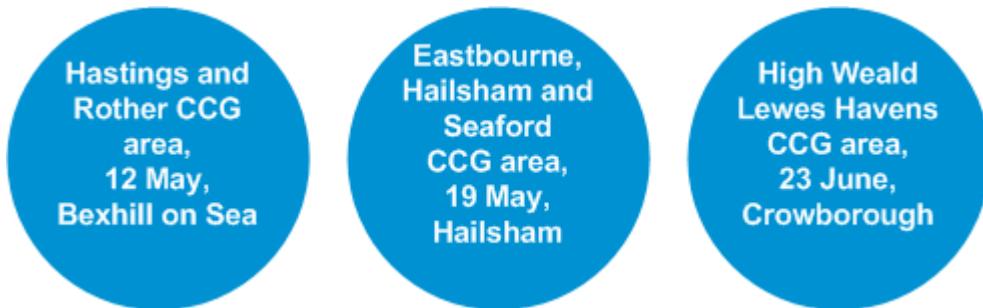


Image: dates and locations of the Spring 2015 events

The events were promoted through the CCG and East Sussex County Council websites, email, social media channels, patient participation groups, voluntary organisations, community groups and strategic partners. More than 200 local people participated in the workshops, together with CCG governing body members, CCG staff and social care staff.

Shaping health and care events form part of our continuing approach to listen to the patient, client and public voice and use this to help shape local health and social care services. The Spring 2015 events were a way for local people to:

- Hear about how the CCGs and the county council have acted on the learning from the previous events in autumn 2014
- Hear about our progress so far with East Sussex Better Together
- Shape and develop key work and raise issues in local areas
- Ask questions and raise issues directly to CCG governing body members and senior social care professionals

What we covered

The sessions opened with a short presentation which gave some history and context to how East Sussex Better Together started in August 2014. Following feedback, this has now been made into a video which you can watch on the East Sussex Better Together website, at <https://news.eastsussex.gov.uk/east-sussex-better-together/>. In summary:



Image: summary points from video

After this presentation, there were table-led discussions on the key areas of focus. These were:

- Integrated health and social care teams
- The re-design of urgent care services
- Growing healthy communities

- Reducing health inequalities (Hastings and Rother and Eastbourne, Hailsham and Seaford CCG areas only)
- Frailty (High Weald Lewes Havens CCG area only)

It's worth noting that although everything tied-in under East Sussex Better Together, the CCG areas focussed on areas of particular interest to their local community.

Each table identified themes and key points from their discussions, which were collated and analysed. This report records an overview of what was discussed, and a summary of what we learned from all three events.

What you said: key themes overall

Networking is vital:

This thread ran through all of the workshop sessions. There is a fundamental need to establish stronger relationships - both formal and informal – between statutory and voluntary services, which would improve knowledge of linked or related services (such as diabetes support groups or even transport options), and provide a more holistic service for local people.

Consistency and promotion of information:

Another key theme was how people can find out about their local community's services, both voluntary and statutory. It was felt that information must be consistent wherever you find it. There were specific discussions around education for local people, especially on where to go if A&E isn't the right solution, and how to better advertise community and support groups.

Having a link:

Lots of people talked about the difficulty in navigating all the different support options available, especially when looking at the 'Nadia's story' case study. Could there be a consistent point of contact to guide people through the health and social care services they might need to use— being the link between statutory and voluntary services, and providing information, support and guidance.

Access to services:

Access to the right services should be fast. There was lots of support for co-location and making sure that the right mix of staff should be put together to support local need. This should be promoted more widely so that people know where to go (see **Consistency and promotion of information** above).

Integrated community teams

This topic looked at how the integrated community teams might work in practice by examining a case study. The questions also covered elements of health equality and growing healthy communities.

Case study: Nadia has type 2 diabetes, and is finding it hard to improve her health and make changes. It's affecting her mental health, and she needs support to make the changes necessary. Her partner Luke is worried, and her doctor also recognises Nadia's need for more support than just "leaflets and advice". Tables discussed Nadia's story, which looked at Nadia's health conditions from three perspectives; hers, her partner's and her doctor's. They focused on four questions:

- 1) In your area today, who might Nadia and Luke talk to first about the situation?
- 2) What can be done differently to avoid this situation getting worse:
 - by the integrated community teams?
 - by other partners or local people?
- 3) How can we make sure everyone can benefit equally?
- 4) If Nadia's health became worse in three years' time, how might this story be different for her? What changes you would like to see?

What you said:

- You would like there to be more peer support options available – it's clear that Nadia is lonely and would benefit from a network of other people
- You would like there to be a shared source of information about support services in the community so that people like Nadia and her partner Luke can both find the support that suits them
- You would like more pooled budgets, which offer a wider range of support options from the integrated community teams
- You would like there to be a consistent point of contact for patients to guide people through the care pathway
- You would like voluntary services and community groups to be more closely involved in the care pathway, forming closer relationships with integrated teams
- You would like the integrated community teams to take a holistic approach to supporting people – linking together different services in the local community

How we have used this information

Much of this feedback is incorporated as part of our blueprint for the integrated community teams. Your feedback influences the way that integrated community teams will work with individuals and the wider community – with a focus on connecting people. We'll build this into how the teams are monitored and measured, too. Specifically, we have been able to use the information you provided at the Shaping health and care events in the following ways:

- As we develop the teams, we will engage with the third sector and voluntary organisations in that area to look at gaps in service and how we can develop peer support options
- As part of the ESBT self-care self-management workstream, a digital hub called Autonomy is being developed to provide information, signposting and advice with links to other websites. There is also a mobile app being developed alongside this
- A key reason for creating the teams and moving to a single line management structure to make it easier to access services
- There is an ESBT workstream developing Health and Social Care Connect, a single point of access for health and social care services. This went live in April 2014 for GPs, and as it develops, it will provide the one place for people to contact. On an individual basis patients and carers with complex needs will be given a named keyworker to help co-ordinate their care

We have now established a community resilience working and voluntary and community sector liaison group to develop relationships with the third sector and informal support networks.

Re-design of urgent care services

Urgent care describes a range of services, including out-of-hours GPs (111), minor injuries units, and Walk in Centres. There had already been two engagement sessions on redesigning our urgent care services, in January and April 2015. The January session had looked at developing a more consistent, sustainable approach, and the April session built on this by agreeing the sort of outcomes that urgent care should deliver, and what a 'good' service would look like.

Attendees at both previous events were very clear that they needed consistency and confidence in the urgent care system. They had also asked for clear links with primary care, the integrated community teams, social care, mental health, dental services, community pharmacists and voluntary services.

Using this input to date, the facilitators explained that the proposed model of the 'Urgent Integrated Care Hub' would be staffed with a similar skill mix as integrated community

teams, with the addition of G.P's, Emergency Nurses or Paramedics, and Healthcare Assistants with minor injury skills. This mix of staffing would make it different from the traditional urgent care centres and A & E's (Accident and Emergency).

At the front end, urgent assessment by a trained urgent care practitioner would be the key to success, with rapid access to Multi-Disciplinary Team assessment, diagnostics, treatments and onward referrals, as needed. Integrated urgent care hubs would provide minor injury and minor illness management and for most people, robust care plans, health education and self-management advice. This should reduce acute hospital admission and better help people who often find themselves in A & E, with the additional benefit of patients having a better urgent care experience.

The tables looked at the work covered so far in detail, and then discussed the following questions around the proposed model diagram:

1. What are the opportunities presented by the different ways the service could be delivered?
2. What are the challenges introduced by the different ways the service could be delivered?
3. What could be put in place to address or lessen the impact of the challenges identified?
4. What needs to be taken into account when considering where these services should be located?

What you said:

- You think that for this to work, the triage would need to be really effective, and work from whichever point. For example, if someone went to A & E when they didn't need to, they should still be able to be effectively directed to the right place
- You think the urgent care hub should be co-located with A & E services, and that the staff should have skills matched to the local community's needs
- You feel that faster access to the most appropriate services is important – and it should be open 24 hours, seven days a week
- Local people don't know about the different options in their area – you think this needs to be publicised widely and in a simple way
- Currently, there are inconsistencies in time taken to process referrals across the county. You would like the referral process to be speedy and efficient across all locations
- You would like information sharing to be improved to avoid repetition. So that, for example, someone with a long-term condition doesn't have to explain everything to urgent care services. This would encourage a more holistic approach

How we have used this information

We have been able to use the information you provided at the Shaping health and care events in the following ways:

- We're currently determining what we want from 24 hour, 7 days a week access to urgent care services
- In our plans for the future services, we have linked response times to referrals, and the ability for people to be effectively referred to the right service, wherever they originally enter the service
- We are developing a full communications and engagement plan for urgent care
- We are developing access to shared care plans and documents which will enable urgent care clinicians/professionals who are working with an individual (with appropriate patient consent) to view shared plans and documents.

Growing healthy communities

The facilitator started by sharing some background information.

A report by the East Sussex Director of Public Health has identified that traditionally, statutory organisations have focussed on the problems that communities have – for example, lower life expectancy, or more health inequalities. The report identified that all communities have some positive aspects, and these help to make communities healthier. By focussing on and growing these positive aspects, we can support communities to make more of their strengths.

Participants then looked at a diagram which broke down all the different elements in a community that can contribute to it being healthy. The table then considered:

1. What community groups and support networks are there already in our local communities?
2. Who uses them, and who doesn't? Who could benefit from using them?
3. What gets in the way – what stops community groups in engaging with people who haven't traditionally joined them, and how might we encourage those people to engage more?
4. How could you (as a community asset) get more involved personally?

What you said:

- There are lots of community groups and networks in East Sussex, and you would like to see more co-ordination between them and voluntary organisations, so that groups work together to tackle local issues
- You would also like to see better use – and sharing – of physical spaces, as well as buildings. Pubs could be used more to attract people who wouldn't normally engage, for example
- You would like us to be better at information sharing; both between care and support professionals, and with the voluntary sector and other key hubs, like schools and care homes
- You would like integrated community teams to have the right local knowledge to be able to link people in to the right community support
- You would like us to focus on publicising support services – with different formats for different age groups

How we have used this information

- Your feedback has been included in a report that went to the first meeting of a new workstream around how we build healthy communities as part of the East Sussex Better Together
- This workstream (called Growing Healthy Communities) will develop a comprehensive and coordinated approach to building healthy communities
- The things that get in the way, and the things that help which were identified in the Shaping health and care sessions will inform the way that the Integrated Community Teams support people to access help in their communities, and how we ensure they have the right knowledge within the teams to do this
- Your comments on information provision and publishing services will be used to inform future plans developed through the Community Resilience workstreams

Reducing health inequalities

This topic was only discussed by Hastings and Rother, and Eastbourne, Hailsham and Seaford CCG areas.

Hastings and Rother has a programme called Healthy Hastings and Rother aimed at reducing health inequalities. The programme was developed following research by East Sussex County Council's Public Health department, examining the causes of poor health in specific areas of the county and identifying where action might best be focused.

Facilitators took table participants through the background of the health inequalities programme, and the work undertaken so far.

The table then discussed ways of improving access to services for many people and explored ideas about how to engage with communities so we can design services together that will reflect how people use services today.

What you said:

This topic was only discussed by Hastings and Rother and Eastbourne, Hailsham and Seaford CCG areas.

- You would like us to do more work helping people to understand the range of services available in communities , especially where there are language or other difficulties in accessing services
- You would like us to use every-day language to make health and social care simpler to understand – jargon can be a turn off
- You would like us to take the time to listen to people in communities and talk to them about the issues local to them
- You would like healthy lifestyle services (such as help to stop smoking or lose weight) to be more focussed on the positive and less ‘judging’

How we have used this information

We have been able to use the information you provided at the Shaping health and care events in the following ways:

- Your feedback has been used to inform the commissioning of projects within the Community Engagement and Consultation workstream of the Healthy Hastings and Rother programme
- A ‘jargon buster’ is being produced for East Sussex Better Together, and we are also working in simplifying the information we produce about projects and the programme in general
- Healthwatch East Sussex are running a Public Reference Forum and are also touring the county to find out what matters to people in local communities – we will use the information in our work
- Your comments on healthy lifestyle services will be shared with current lifestyles service providers, to inform how they promote and deliver current services. They will also be used to inform future plans to support people to make lifestyle changes e.g. through the East Sussex Better Together workstream on Primary Prevention, Self-Care and Self-Management

Frailty

This topic was only discussed by the High Weald Lewes Havens CCG area.

The CCG wanted to develop more effective ways of caring for the frail elderly. The process for doing this is called a ‘care pathway’. Facilitators asked the participants to consider the key features of such a pathway and consider some specific questions:

1. GPs are well placed to work with the frail elderly who often have more than one health issue. However we need GPs to work as efficiently as possible to meet the needs of their populations. It has been suggested that in certain circumstances, where clinically safe and appropriate, people may be able to go directly:
 - to a physiotherapist, e.g. in the case of back pain
 - to a counsellor, e.g. for mild to moderate depression.

Would you support this way of working for people to access the appropriate services?

2. We know from patient feedback that the elderly in particular have difficulty accessing services. We also know that people living in Peacehaven and Newhaven experience poorer health outcomes (known as health inequality). Therefore we have piloted a service with a local charity “Community Transport for the Lewes Area” (CTLA), to provide transport from Peacehaven and Newhaven, to GP practices and to the Lewes Victoria Community Hospital.

Do you think this service should be continued?

Do you think people should be assessed for eligibility? This could indicate who will need to pay, make a contribution or receive free transport.

3. If patients have a named health or care professional whom they see, they may need to wait to see that individual each time.

What is more important to you - continuity of care (seeing the same person) or how quickly you can access somebody who can help you?

Does it depend on the circumstances and why?

4. ‘Anticipatory Care Planning’ is a process designed to support patients living with a chronic long-term condition. It plans ahead for a change that is expected to happen at some point in the future. Communication with relatives and carers regarding these plans is of key importance.

How and where in the process, should they be involved?

5. It is recognised that End of Life Care (or frailty planning) should begin as early as possible. Specific plans are required for different circumstances, for example when somebody is confused.

If we could arrange for somebody with training and skills in a particular area, for example confusion, to see or speak to an individual – do you think it would be a good idea? This skilled person might be instead of the GP in that scenario.

What you said:

This topic was only discussed at High Weald Lewes Havens CCG area.

- You debated the pros and cons of people being able to go directly to a physiotherapist or counsellor, and agreed that it's more important that once a referral has been made (by a GP, for example) access to a physiotherapist or counsellor should be quick
- You support the community transport for local hospitals, and think it should continue, although you recognise that drivers need specific training around moving and handling, and also to be dementia friendly
- You support early conversations about managing long-term conditions and End of Life Care, and involving family and carers in those conversations too
- However, you would like there to be a consistent named person that people can talk to, and feel confidence in – doesn't necessarily need to be a GP

How we have used this information

We have been able to use the information you provided at the Shaping health and care events in the following ways:

- The integrated community teams will be adopting a proactive model of care where people will be identified early and supported to manage their condition
- As part of the new model of care for the integrated community teams, people with complex needs will have a named keyworker to co-ordinate their care

Your questions answered

There was an opportunity for participants to ask questions to the panel. There was a lively discussion and we've used the questions that were asked to inform the contents of this report.

Your feedback about the event and suggestions for future events

Did people enjoy the events?

Yes. Overwhelmingly the feedback was positive. People liked the opportunity to have group/shared discussion the most and many wanted even more of it. Our facilitators received lots of praise.

What did people not like, or what didn't work?

If the projector slides were too small (Hailsham) or the speakers were unclear or reading a script (Hailsham and Crowborough) - then this affected how people felt about the event.

What were the suggestions?

These varied widely and some were personal to that individual. Some people wanted to know who else was at the event, or were unaware that certain groups were represented - so an attendee list on each table would be useful in the future.

Would they come again?

Of the 90 people who completed an evaluation form, 87 people said they would come to an event again.

Next steps

As always at these events, all of the conversations that took place were recorded by a member of staff. These have been grouped into the common themes that are shown in this report. This information has been shared within the CCGs and social care so that the lead managers responsible for commissioning the services relating to the priority areas discussed have all of the ideas and information you shared.

The learning is directly informing the development of our plans as part of the East Sussex Better Together programme.

Future opportunities

We are committed to ensuring any decisions we make as part of East Sussex Better Together are informed by ongoing engagement with local people, NHS and social care professionals and partner organisations.

Here are some of the ways you can keep in touch and get involved as the programme develops:

- **Subscribe to our mailing list** to receive news briefings: you can do this at our website: <https://news.eastsussex.gov.uk/east-sussex-better-together/subscribe/>
- **Attend an event** – we'll post all planned events on our website, and will email everyone who signs up for our briefings. In addition, we'll always contact community groups and key contacts to spread the word and promote events in the usual ways
- **Public reference forum:** We have launched a public reference forum to increase ways for you to have a say and inform the development of local services under East

Sussex Better Together. The forum is managed by East Sussex Community Voice (ESCV), which also provide Healthwatch East Sussex. This arrangement builds on work that is already underway to increase understanding about East Sussex Better Together, make sure people's experiences inform our thinking, and enable local people, clinicians and professionals to work together to co-design health and social care services. ESCV has recruited a member of staff to lead the forum and its activities. For more information, contact Frances on pforum@escv.org.uk