

Report to: **Cabinet**

Date: **1 May 2007**

By: **Director of Adult Social Care**

Title of report: **East Sussex Older Peoples Joint Commissioning Strategy**

Purpose of report: **To seek Cabinet approval for the East Sussex Older Peoples Joint Commissioning Strategy.**

RECOMMENDATIONS

The Cabinet is recommended to agree the East Sussex Older Peoples Joint Commissioning Strategy and note its future development.

1. Financial Appraisal

1.1 The Strategy will be implemented within the financial planning for Adult Social Care for the three years 2007/08 to 2009/10. (A copy of the full Strategy can be found in the Member's Room and the Cabinet Room. An Executive Summary is attached at Appendix 1)

1.2 Monitoring the implementation of the Strategy will be linked to the Reconciling Policy and Resources process each year.

2. Background and Supporting Information

2.1 The Strategy describes how health, supported housing and social care will change in the next few years. It sets out the commitments being made by the organizations responsible for these services, to work jointly to improve the experience of those people who use them and get the most out of available resources.

2.2 The Strategy is based on a jointly commissioned assessment of needs, a review of models of best practice, an evaluation of how current services are performing, and what service users and stakeholders have told us.

2.3 Priorities for the first year of implementation with clear direction for the following two years are contained within the Action Plan (attached at Appendix 2).

2.4 The Strategy reflects the strategic priorities set by Government, most recently in the White Paper '*Our Health, Our Care, Our Say*' and supports strategic planning within each of the partner organizations.

2.5 The Strategy has been subject to engagement and consultation with key stakeholders. Further consultation will take place with stakeholders during the implementation of the Strategy

2.6 The Strategy provides a clear strategic direction for delivery of services for older people in East Sussex. It sets out a clear explanation of how this relates to the local and national policy and addresses the challenges we face in East Sussex. The Strategy provides a mechanism for joint working with health and housing organisations within East Sussex.

2.7 The key points within the Strategy are contained within the Executive Summary.

2.8 The Strategy supports the Adult Social Care Three Year Plan and the Commission for Social Care Inspection (CSCI) Inspection of Social Care Services for Older People in East Sussex Action Plan (June 2006) – *Recommendation 2.1 'The council should ensure that the development of a joint commissioning strategy with shared needs analysis is a priority and receives full support across the health economy'*

2.9 An Equality Impact Assessment has been undertaken and more detailed engagement and liaison is planned to ensure that the needs of minority groups are fully considered. Significant engagement, involvement and consultation have been undertaken during the development of the Strategy and will continue to be used to inform and shape the implementation.

3. Conclusion and Reasons for Recommendation

3.1 Cabinet is recommended to agree the Strategy, which provides a clear statement of commissioning intentions, a mechanism for longer term joint working; strategic planning; and needs assessment of older people in East Sussex.

KEITH HINKLEY
Director of Adult Social Care

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Local Member: All

BACKGROUND DOCUMENTS:

1. Adult Social care Three Year Plan
2. CSCI Inspection of Social Care Services for Older People in East Sussex (June 2006) – Action Plan

East Sussex County Council
East Sussex Downs and Weald Primary Care Trust
Hastings and Rother Primary Care Trust

**JOINT COMMISSIONING
STRATEGY
FOR OLDER PEOPLE**

April 2007

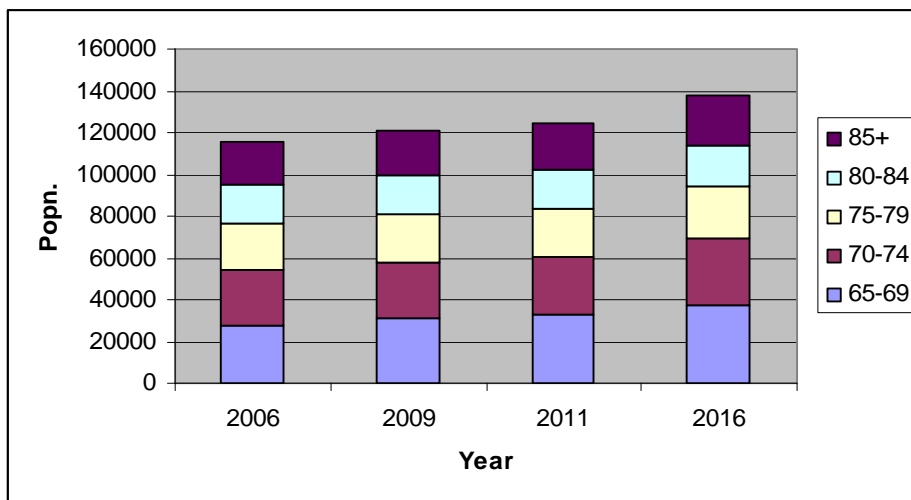
JOINT COMMISSIONING STRATEGY FOR OLDER PEOPLE

EXECUTIVE SUMMARY

Introduction

This Commissioning Strategy describes how health, social care and supported housing services will change for older people in the next few years. It sets out the commitments being made by the organisations responsible for these services, to work jointly together to improve the experience of those who use them and get the most out of available resources.

The population of East Sussex is changing and there will be more people living to an older age in the future. This is illustrated in the diagram below.



Health social care and housing services have to respond to these changes and the commissioning process is a key mechanism for achieving this.

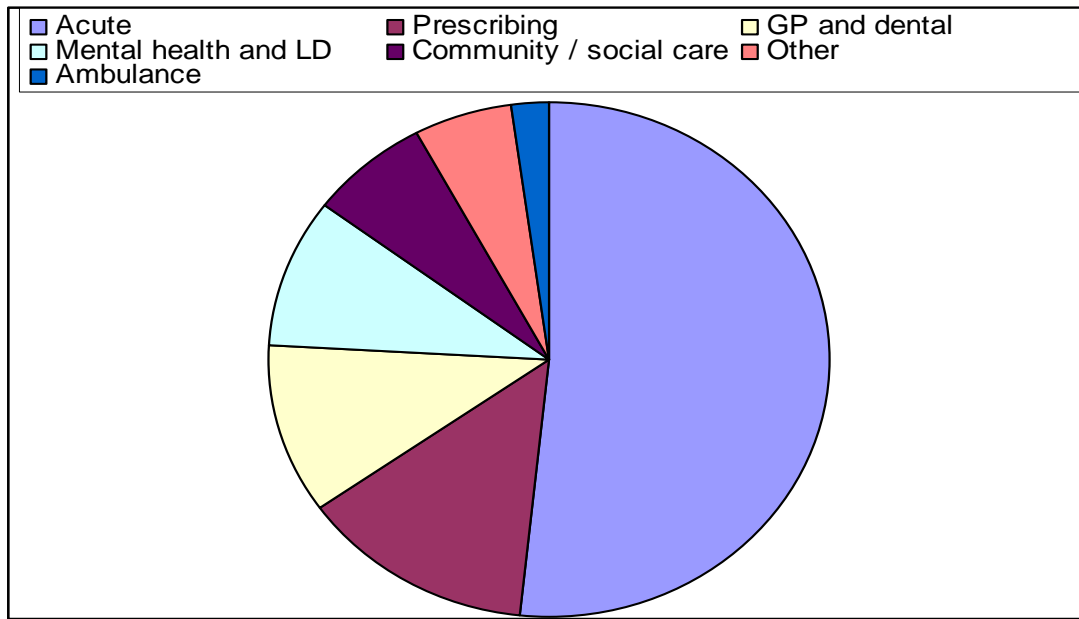
The strategy is based on an assessment of needs, review of models of best practice, how well existing services are performing and what our patients, service users and stakeholders have told us. Its focus is on prevention and promoting health and well being by providing more care closer to home, in line with national policies.

In the local context of financial constraints it is important that we are transparent and work in partnership to make the best use of resources as well as improve outcomes for local people. Good examples already exist of how this is being done, including work with the voluntary sector and consultations with stakeholders informing our strategy.

There will be new sorts of 'care pathways' developed in the future, with more focus on helping older people to enjoy good physical and mental health through prevention and supporting people to look after themselves. Older people who are at risk will benefit from early intervention services to prevent or delay them from developing problems that may otherwise lead to hospital or Care Home admissions, which is where most of our money is currently spent.

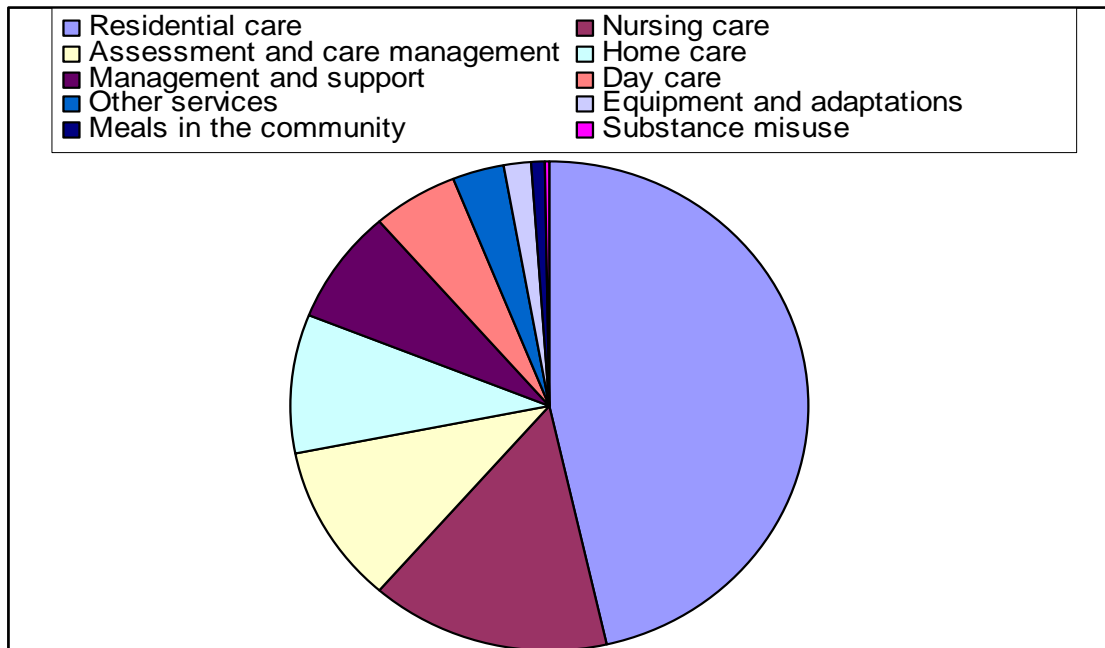
This is illustrated in the following Diagrams:

NHS (PCT) Expenditure in 2005/06



Source: East Sussex LHC Sustainability and Integrated Service Improvement Plan.

Adult Social Care Expenditure in 2005/06



As higher than average numbers of older people at all ages live in East Sussex and these are set to increase in the future, demand for existing services will increase especially sharply over the next ten years. At the same time costs will also rise and this situation will not be sustainable in the longer term.

There is an opportunity before then to reduce reliance on hospital and residential care services, and as we know what problems most affect older people, we can target our resources on addressing their particular needs.

For example, it is often as a result of falls, stroke, chronic obstructive pulmonary disease (COPD: made up of various respiratory diseases) or dementia that older people develop a long term need for health, social care and housing services, even though there is good evidence on how to improve the treatment and care management of these problems, and those with more complex needs.

Care will be co-ordinated or 'managed' jointly between agencies in the future, and a range of services will be able to respond to emergencies quickly and in accordance with their seriousness. There will be opportunities for avoiding admission to hospital, maximising recovery, and options for providing long term support.

Key Strategic Developments

The Strategy sets out a wide and comprehensive range of proposals for change, which relate to the different stages at which people come to need and use health and social services or their housing needs change.

The development of better joint working and the co-ordinated management of care and treatment provided by health and social care staff however, is vital at all stages. Providing opportunities for those people receiving services to make more choices and take more control will also help to maintain their independence. Together with finding ways to jointly target shared resources, this will therefore be an early and key strategic development to be implemented.

A joint focus on improving local intermediate care services to ensure they target local need will be a key priority as these focus on preventing admission to hospital or Care Homes, and facilitate discharge and recovery by the provision of rehabilitation and opportunities for recuperation.

Primary care and general practice will continue to play its vital role in the improvement of preventative services, which together with voluntary sector developments that promote health and well-being, such as those delivered through the partnership arrangements of the Local Area Agreement, should improve the quality of life enjoyed by older people in the future by looking outside of those only provided by health, social care and housing.

On-going support will also become increasingly important as older people live longer, and so key strategic developments will include more intensive home care being available in the future, together with sheltered, extra care and supported housing schemes, that will help support independent living for as long as possible. This will also enable older people to remain within their community and continue to take an active role in local activities.

Housing related support will become more flexible as it reduces its link to sheltered housing schemes, and more extra care housing is planned in the future. Should a move to a Care Home become necessary, help will be provided with finding an appropriate place, and end of life 'palliative' care will also be improved. Maintaining the standards of quality care provided in these settings will enable people to maintain their personal dignity.

Tackling the Main Problems that affect Older People

A review of existing services in East Sussex identified where there are already developments under way in these areas and what opportunities exist for making improvements in the future.

Falls – Falls can have a serious effect on the physical and mental health of older people, leading to reduced independence. The risk of falling is reduced by GPs reviewing medications, home hazards being removed and exercise being taken in organised classes. Ambulance crews have been trained to treat minor injuries in the home to avoid having to go to A & E, and help is available for those who fall at home to be helped up and settled.

Specialist teams exist that accept referrals of those screened as being at risk of falling in the future, and carry out multi-factor assessments and provide care and treatment to address needs. These teams will practice in a more consistent way across East Sussex in the future.

Stroke – Healthier lifestyles and GP prescribing can reduce the risk of first and future strokes, and as specialist care in hospitals and from community rehabilitation teams is known to improve outcomes, these will be better co-ordinated and provided more consistently across East Sussex in the future.

COPD (made up of various respiratory diseases) – Help with stopping smoking is the best way to prevent COPD and reduce its severity. Specialist teams that can support patients to manage their COPD can prevent acute episodes which currently result in hospital admissions. We will review how we manage our services to support this particular client group.

Dementia – As the causes of dementia are not known its prevention is not possible, but services can and do provide information and support to help cope with its effects, and an early intervention service is also being piloted. Community Mental Health Teams provide on-going support to people who suffer from depression as well as dementia, and intensive support at home is available to prevent hospital admission which can exacerbate confusion.

In-patient units for older people with mental health problems will be reconfigured and improved, and for older people admitted to acute hospitals who also have mental health problems, a new liaison service has been introduced. Similar developments are planned to support mainstream rehabilitation and intermediate care services. Consideration of the needs of people with dementia will also be made when designing and developing new extra care housing schemes.

Complex Needs – Healthier lifestyles are encouraged by GPs and by funding voluntary sector-provided services that promote health and well being. Community health and social care staff assess the needs of older people who are most at risk and manage their care to prevent deterioration. Waiting times for assessment and service provision will improve focusing on more personalised care and better outcomes for older people, also more control can be taken by individuals to organise their own care.

Delivering the Strategy

The order in which strategic developments will be tackled is based on what costs and benefits they will deliver, and within what timescales. Investment in priority areas has been identified by both the PCT and Adult Social Care Services as the commissioners of these services. It will be necessary to ensure there is sufficient capacity in both organisations to see them through, that health and social care continue to work in partnership with other agencies and the workforce is developed to deliver.

A series of Action Plans set out in detail what will need to happen to bring about the changes we wish to see, and governance and accountability arrangements have been put in place to oversee progress and ensure accountability. There will be a Joint Executive Group of Chief Officers from health and social care organisations and a Whole System Leadership Group of senior managers.

A Partnership Board for Older People will include membership not only from health, social care and housing organisations but also the voluntary sector and representatives from local Older People's Forums. A number of sub-groups that will be responsible for the action plans already exist, and these will be added to as necessary to ensure all developments are delivered.

Investment in the Future

The Primary Care Trusts and Adult Social Care Services face significant financial challenges in meeting the needs of older people in East Sussex. However both have identified increased investment over the next 3 years to support key strategic developments and tackle the main problems that affect older people.

NHS / PCT Investment Plans to 2009/10

Service Development / Cumulative Investment [1]	2007/08 £'000	2008/09 £'000	2009/10 £'000
Enhanced Team in A & E / MAU	200	350	580
Community Intermediate Care	0	100	200
STAN	220	250	250
Falls Service	325	529	575
COPD	0	189	189
Heart Failure	46	121	150

Adult Social Care Services Investment Plans to 2009/10

Service Area / Baseline 2007/08 & Cumulative Investment [2]	2007/08 £'000	2008/09 £'000	2009/10 £'000
Assessment and Care Management	374	973	148
Nursing Care	721	1,085	1,137
Residential Care	1,428	956	1,430
Home Care	302	365	451
Day Care	97	(45)	(100)
Meals in the Community	22	20	20
Other Services	18	29	27

[1] Excluding Inflation [2] Including Inflation

Risks

The risks associated with this Strategy relate to the effectiveness of the partnership working that underpins the Joint Older Peoples Commissioning Strategy and the significant changes that will be required in implementing the Action Plans.

The key risks in implementing the Strategy are as follows:

- The role of partnership in delivering improvements to services within East Sussex will be critical. Ensuring the wellbeing of our community requires

integrated working across statutory, independent, and voluntary sector partners. Improvements in the co-ordination of health, housing and social care services are essential given the interdependent nature of care across agencies. The continued development of more effective ways of working across all sectors is essential in sustaining improvement in outcomes for older people in East Sussex.

- Although prudent assumptions have been made about organisational budgets and specific grants received from Government, the withdrawal in whole or part of a range of specific grants and allocations by central government continues to present a risk to our financial planning.
- The level of change required to deliver the Strategy across all agencies is significant. There is a need to ensure the effective management of this programme as a whole as well as the requirement to identify sufficient management capacity to deliver the objectives of the Strategy.
- Whilst the Strategy provides a clear direction and specific actions, partner organisations will be required to respond positively to policy and legislative changes.
- Delivering improvements to services will inevitably mean changes for people currently providing and receiving services which may not always be favourably viewed. The management of these changes for staff and those people receiving services will be critical elements in the successful delivery of the Strategy.

Equalities

Although the Strategy focuses on the needs of the general population of older people in East Sussex, we are aware of specific groups within that community with additional needs such as those from black and minority ethnic groups (BME), those with cultural or lifestyle factors that affect their health, social care or housing requirements and others.

Good progress has already been made on completing an 'Equalities Impact Assessment' on the Strategy, which will be subject to consultation in a series of stakeholder events organised to take place in the summer. The need to address any issues arising from these events has been highlighted in our Action Plans, which will continue to be evaluated and addressed throughout the implementation of the Strategy.

Conclusions

This is a three year Strategy. Implementation will be monitored, reviewed and refreshed each year in consultation with a wide range of stakeholders including those who use the services. The Strategy provides the mechanism for the delivery of improved outcomes for older people in East Sussex. It represents a significant development in partnership working between health, social care and housing and their undertaking to work together with other agencies in improving the physical and mental health and well being of older people in East Sussex.

Action Plans

We now set out in a series of action plans what we will do over the next three years to realise the aims and objectives of our strategy. These are related to the hypotheses that came out of the Stakeholder events we held and which are described in Section 1.5 and in Appendices 2 and 3.

HYPOTHESES

You are asked to identify where you believe key blocks, inefficiencies and gaps might occur. These can then be worked up into 'hypotheses'. Examples of hypotheses from older people services might include:

- 'Investing in extra care housing will allow us to reduce the number of residential and nursing beds we purchase.'
- 'We are going to need to increase the volume of services by 20% over the next 5 years if we are to keep pace with demand.'
- 'If we transferred funds from the local acute hospital to primary care services for older people with dementia, we would be able to increase the number of people who are supported at home and reduce the demand for beds. This would be a more effective use of our resources.'
- 'A lot of the tasks undertaken by community health professionals could be done by less qualified and less expensive staff, costing less money, and allowing us to distribute services more widely.'
- 'Over half of the users of our day care services do not need them, and there are more effective and cost-effective ways of providing community support for them and their carers.'

Once they have been agreed as suitable, the steering group then needs to ensure that the hypotheses are fully investigated during the course of the project, and accepted or refuted on the basis of the evidence gathered.

Where accepted, they can then rightfully play an important role in defining service direction.

We also indicate which outcomes from the White Paper 'Our health, our care, our say: A new direction for community services' these actions aim to deliver.

OUTCOMES FROM THE WHITE PAPER
'Our health, our care, our say: A new direction for community services'

Improved health: enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long-term conditions independently. There are opportunities for physical activity.

Improved quality of life: access to leisure, social activities and life-long learning and to universal, public and commercial services. Security at home, access to transport and confidence in safety outside the home.

Making a positive contribution: active participation in the community through employment or voluntary opportunities. Maintaining involvement in local activities and being involved in policy development and decision-making.

Exercise of choice and control: through maximum independence and access to information. Being able to choose and control services and helped to manage risk in personal life.

Freedom from discrimination or harassment: equality of access to services. Not being subject to abuse.

Economic well-being: access to income and resources sufficient for a good diet, accommodation and participation in family and community life. Ability to meet costs arising from specific individual needs.

Personal dignity and respect: keeping clean and comfortable. Enjoying a clean and orderly environment. There is availability of appropriate personal care.

2 CSCI outcomes

Inspecting for Better Lives: A Quality Future

- **Leadership & Management:** People experience services that are well led.

A New Outcomes Framework for Performance Assessment of Adult Social Care

- **Commissioning & use of resources:** Adult Social Care commission and deliver services

In the early stages of the implementation of these Action Plans we will be developing in more detail what each of them will involve us doing, who will be responsible for taking them forward, and in what timescales. These plans and progress against them will then be monitored through the governance and accountability arrangements described in the next section.

6.3.1 Fit and Well although Growing Older

STAKEHOLDER HYPOTHESES	ACTIONS	PRIORITY / YEAR
Quality	1. Develop approach to the completion of a 10-15 year joint needs assessment. Outcome: Commissioning and Use of Resources	Year 1
Prevention	2. Develop a strategy for promoting and improving the health and well-being of older people that focuses primarily on the key priority areas in tackling health inequalities, reducing smoking, tackling obesity, improving sexual health, mental health and well-being, reducing harm and encouraging sensible drinking, with recommendations for actions. Outcome: Improved Health	Year 1-2
Well Being	3. Via the further development of the Local Area Agreement, continue to build closer working within the East Sussex Strategic Partnership to improve the health and wellbeing of older people in East Sussex and reduce inequalities within the County. Specifically, in line with priorities to: <ul style="list-style-type: none"> • Promote physical and mental wellbeing, including reducing falls, reducing premature mortality rates from heart disease, stroke, cancer and suicide and reducing the effects of smoking • Improve access to information, services and opportunities that support healthy, active lives; including improving economic wellbeing • Improve independence, well being and choice, including the establishment of an interagency referral system to ensure individuals receive support from all appropriate agencies • Improve the user, patient and carer experience of services Outcome: Improved Quality of Life	Year 1-2
Prevention	4. Provision of 'health checks': <ul style="list-style-type: none"> • Improved information and access to a range of health check services including sight checks • Training for staff on prevention and health promotion in a range of settings including voluntary sector day care, interest groups etc. Outcome: Exercise Choice and Control	Year 1
	5. Promotion of 'Active Aging' initiatives <ul style="list-style-type: none"> • Building on (for example) Active Hastings 	Year 1

Well Being	<ul style="list-style-type: none"> Promoting Quality of Life with Seniors Forums 	
	Outcome: Improved Quality of Life	
Prevention	6. Respond to the Recommendations of the Scrutiny Review of Preventative Services	Year 1
	Outcome: Leadership and Management	
Joint Working	<p>7. Continue to implement and develop the Older People's Involvement Strategy to promote active participation in the community and involvement in policy development and decision making</p> <ul style="list-style-type: none"> Increasing numbers of seniors involved in the network of forums across East Sussex Development of Older Peoples Partnership Board Development of a corporate approach to older people's priorities through the establishment of the Interdepartmental Older People's Working Group Development of a strategic approach for Improving Wellbeing and Quality of Life for Older People encompassing both the priorities directly led by local older people and Adult Social Care's strategic approach (as reflected in this Commissioning Strategy) 	Year 1 -3
	Outcome: Making a Positive Contribution	
Joint Working	<p>8. Working in partnership with the voluntary sector to provide preventative services and social opportunities:</p> <ul style="list-style-type: none"> Over time, ensuring contracts are better aligned to commissioning priorities and focussed on outcomes Contract with the VCS to provide aspects of services which we have traditionally provided ourselves. Support to The Compact and other VCS development initiatives 	Year 1
	Outcome: Commissioning and use of Resources	
Information	<p>9. Access to simple aids and equipment to enable independent living at home:</p> <ul style="list-style-type: none"> Revise assessment arrangements including by phone and internet in order to speed up and simplify the process providing better information regarding the access to this equipment assess and make provision as necessary for increased demand arising as a result 	Year 1
	Outcome: Improved Quality of Life	
	<p>10. Improve the response when providing assessments:</p> <ul style="list-style-type: none"> Increase the proportion of people who experience acceptable waiting times for assessments for 55% (current) to 90% (by 2009/10) (Adult Social Care) 	Year 1

Quality	Outcome: Leadership and Management	
	11. Improved focus on older people with mental health needs, particularly dementia: <ul style="list-style-type: none"> • Pilot and evaluate MAST service • Training to identify and respond to the early signs of dementia 	Year 1-2
Quality	Outcome: Improved Health	
	12. Address any issues arising from consultation events taking place in the summer on the 'Equalities Impact Assessment' on the Strategy. 13. The detail of the Implementation Plan will ensure Equalities issues are addressed.	Year 1
Equalities	Outcome: Freedom from discrimination or harassment	

6.3.2 Experiencing Problems that might be Preventable

STAKEHOLDER HYPOTHESES	ACTIONS	PRIORITY / YEAR
Joint Working	<p>1. <i>Develop plans to integrate the 2 CMHTs for older people into 2 PCT teams which will improve economies of scale, patient expertise and response.</i></p> <p>Outcome: Commissioning and Resources</p>	Year 2
Information	<p>2. To develop and provide information for older people and their carers on how to self care and what facilities and services are available to them in the local community, including housing related grants and assistance with meeting costs. Information to be provided in a range of different ways informed by local older people groups e.g. internet, leaflets, posters, video, telephone.</p> <p>Outcome: Exercise of Choice and Control</p>	Year 2
Equalities	<p>3. Review how to simplify information about access routes to services so that it is simple, clear and consistent for local older people and their carers to understand.</p> <p>Outcome: Improved Health</p>	Year 1-2
Prevention	<p>4. To develop a range of non 'care' managed preventative services as part of the wider prevention agenda e.g. confidence building; tackling loneliness and isolation; utilisation of telecare; self care (expert patient or carer programmes and condition specific training by users or voluntary sector).</p> <p>Outcome: Improved Quality of Life</p>	Year 1-3
Joint Working	<p>5. Develop an East Sussex wide strategy and care pathway for the management of patients with chronic disease. To include:</p> <ul style="list-style-type: none"> ▪ Self care and information ▪ Managed care of single disease (expert patients and carers programmes, carer care pathways) ▪ Management of people with complex needs (very high intensive users) <p>Outcome: Exercise of Choice and Control</p>	Year 2-3
Prevention	<p>6. Review the current methodology for proactive identification of patients at risk of deterioration or hospital admission as a result of chronic disease and ensure consistent implementation across East Sussex.</p> <p>Outcome: Exercise of Choice and Control</p>	Year 1-2

	<p>7. Ensure the older person is at the centre of managed care and case management and the single assessment process. Encourage staff to obtain the users consent as part of SAP process to assist with ensuring users are part of the ongoing process.</p> <p>Outcome: Exercise of Choice and Control</p>	Year 1-3
	<p>8. Ensure that all patients with complex chronic disease needs have an individualised care plan by April 2008 and to continue implementation of Single Assessment Process and targets re the reduction of multiple assessments.</p>	Year 1-2
	<p>9. Review ways in which the Adult Social Care care management process can be improved.</p>	Year 1-2
	<p>10. Review the role and function of community matrons to include:</p> <ul style="list-style-type: none"> ▪ How patients are identified (threshold of risk) ▪ How patients are assessed / managed – balance between new assessments and ongoing case management ▪ Case management of patients when enter acute hospital (A&E and wards) ▪ Response times / actions – 7 day a week working 	Year 1-2
	<p>11. To promote and clarify the role of specialist nurses and community matrons to patients, carers and staff.</p>	Year 1-2
Joint Working	<p>12. Explore opportunities and test out ways for improved joint working in the management of care for people with complex needs and / or chronic disease between health and adult social care. For example:</p> <ul style="list-style-type: none"> ▪ Develop approaches where only one worker is the named case manager for an individual patient irrespective of organisation and who will be responsible for supporting and assisting that patient and their carer and for liaising with all other organisations involved with their care ▪ Test out locality based joint case management teams that proactively identify those people in their locality at risk of admissions to hospital (complex needs) and who between the team jointly case manage these patients together – team could include community and specialist nurses, community matrons, social workers, therapists, pharmacists, GPs ▪ Consider use of formal legislation to support joint working e.g. Health Act Flexibilities <p>Outcome: Leadership and Management</p>	Year 1-2
	<p>13. To further develop medicines management plans aimed at supporting older or vulnerable people in the community with complex or changing medication regimes (especially where patients have recently been</p>	Year 2

	discharge from hospital). To include the role of local pharmacists and new pharmacists contract. Outcome: Exercise of Choice and Control	
Well Being	14. Develop health promotion activities within the stroke and falls strategies to include: <ul style="list-style-type: none"> ▪ Promoting healthy lifestyles ▪ Diet / weight management ▪ Stop smoking ▪ Exercise Outcome: Improved Health	Year 1-2
Quality	15. Develop and implement COPD care pathway and services that reflect national best practice and local needs. Outcome: Improved Health	Year 2-3
Equalities	16. Review day services for older people with mental health needs so that these services can be provided closer to home and are condition specific e.g. specialise in either organic (dementia) or functional (e.g. depression). Outcome: Commissioning and use of Resources	Year 1-2
Quality	17. Develop and enhance mental health services for older people in peoples own home, rather than community beds – this will involve transfer of resource from community beds to home based services. Integrated current bed based services from 4 units to 2 – one per each PCT area aligned with proposed CMHTs. Outcome: Personal Dignity and Respect	Year 2-3
	18. Explore the potential for a challenging behaviour service – 8 inpatient beds (for crisis and respite) and specialist assessment and outreach team to support older people with extremely challenging behaviour and their carers to manage as independently as possible at home. Outcome: Personal Dignity and Respect	Year 2-3
Information	19. To improve support for private fee payers of social care services with appropriate and consistent levels of information and advice as non private fee payers. Outcome: Economic Well Being	Year 1-3

6.3.3 In Immediate need of Help or Treatment

STAKEHOLDER HYPOTHESES	ACTIONS	PRIORITY / YEAR
Prevention	<p>1. To continually scrutinise STAN (Single Telephone Access Number) data to identify key clinical conditions that could be managed as safely and effectively within the community if there were the appropriate care pathways and/or services in place and to develop care pathways and services that can prevent avoidable admissions.</p> <p>Outcome: Leadership and Management</p>	Year 1
	<p>2. Ensure best use is made of existing community-based services and aim to increase direct admissions from community / STAN to prevent avoidable admissions to from hospital.</p>	Year 1-3
Carers	<p>3. Ensure all appropriate community services are alerted and respond quickly when patients they case manage arrive in the Emergency Care Department e.g. community matrons, specialist nurses, Community Mental Health Teams. Aim for these teams to make contact with older person, carer and hospital worker so that they can assist with their timely and appropriate discharge home.</p> <p>Outcome: Improved Health</p>	Year 1-2
Joint Working	<p>4. Explore opportunities for those community staff that work out of hours e.g. community nurses, GPs, ECPS to be based together in the emergency care department to help prevent avoidable attendances to A&E or admissions to hospital and enhance joint working.</p> <p>Outcome: Leadership and Management</p>	Year 1-2
Joint Working	<p>5. Review the current pathways within the emergency care department and how the members of the multi-disciplinary team work together to proactively assess and support older people and including with mental health needs arriving at hospital as an emergency with a view of timely discharge from A&E. Explore opportunities for experienced medical leadership of MDT in A&E.</p>	Year 1-2
Prevention	<p>6. Undertake a review of why older people are coming to A&E to identify ways in which some of these people can be managed more effectively at home rather than hospital.</p> <p>Outcome: Leadership and Management</p>	Year 1-2
	<p>7. Develop service and schemes that proactively identify and provide support to carers to assist in prevention of avoidable admissions – see carers strategy</p>	Year 1-2

Carers		
Carers / Information	<p>8. Provide older people and carers with user friendly information regarding alternatives to A&E. To develop these in conjunction with older people forums and user groups. Information to be provided from places used frequently by older people e.g. GP practices, libraries, user groups</p> <p>Outcome: Exercise of Choice and Control</p>	Year 1-2
Equalities	<p>9. Explore opportunities for development of 'phone before you go' for patients as a local alternative to A&E. This will provide older people and their carers with alternative options for care other than A&E e.g. signposting.</p> <p>Outcome: Exercise of Choice and Control</p>	Year 2-3
Joint Working	<p>10. Review current Intermediate Care services including beds for rehabilitation and respite care and develop East Sussex wide Intermediate Care Strategy. To include:</p> <ul style="list-style-type: none"> ▪ Joint definition ▪ Development of non bed based IC services (e.g. rapid response at home and use of day hospitals) ▪ Single assessment process (including shared documentation and IM&T) ▪ Joint training and workforce opportunities ▪ Specialist input from mental health ▪ GP/Consultant leadership within IC services – part of teams ▪ Use Intermediate Care Units and Community Hospitals as a 'hub' for joint teams and local voluntary groups. <p>Outcome: Improved Health</p>	Year 1
	<p>11. Review effectiveness of the current stroke rapid access clinics as part of the review of the stroke care pathway to identify improvements that can be made.</p> <p>Outcome: Commissioning and use of Resources</p>	Year 1
	<p>12. Develop and implement an East Sussex wide Falls care pathway and strategy. To include:</p> <ul style="list-style-type: none"> ▪ Review of Falls assistance service (man with a van) – dependent on outcomes ensure service is sustained ▪ Review of Emergency Care Practitioner Falls Service - dependent on outcomes ensure service is sustained ▪ Continually review and improve current falls services across East Sussex 	Year 1-2

	Outcome: Improved Health	
Prevention	13. <i>Evaluation of new intensive community support service for older people with mental health needs – a service that provides intensive homecare support to older people with mental health needs in the community to prevent avoidable admission to hospital.</i> Outcome: Commissioning and use of Resources	Year 1
Equalities	14. Reconfigure inpatient mental health services to provide fewer more specialist facilities and shift investment in to more community based services. Outcome: Commissioning and use of Resources	Year 1-2
	15. Review effectiveness of navigator service and make recommendations for improvements.	Year 1

6.3.4 Ready or Preparing to go Home

STAKEHOLDER HYPOTHESES	ACTIONS	PRIORITY / YEAR
	<p>1. Improve hospital discharge planning processes. To include:</p> <ul style="list-style-type: none"> ▪ Development of East Sussex wide Choice Policy underpinned by implementation and training programme for staff and patients ▪ Consistency in application of Free Nursing Care – including improved information for and involvement of patients, their carers and social care ▪ Consistency in application of Continuing Health Care - including improved information for and involvement of patients, their carers and social care ▪ Development of clear care pathways and assessment processes for people in hospital who require housing support ▪ Early identification and management of people in hospital who are likely to experience a long length of stay due to their recovery from an operation, clinical condition or complexity of needs ▪ Training and support to the hospital multi-disciplinary teams (staff and clinicians from the agencies involved in discharge planning) to ensure that the best discharge practice is implemented in the acute and community hospitals to ensure improved patient experience focused <p>Outcome: Leadership and Management</p>	Year 1-2
	<p>2. Develop plans to increase levels of discharges at weekends – to include review 7 day a week working for staff</p> <p>Outcome: Improved Quality of Life</p>	Year 1
Information	<p>3. Explore improved use of discharge lounges. Develop patient information leaflets re role of discharge lounges in supporting an increase in morning ward discharges.</p> <p>Outcome: Improved Quality of Life</p>	Year 1
	<p>4. Further understand and address transport issues that delay a patients discharge from hospital</p>	Year 1
	<p>5. Development of single hospital patient held discharge records that older people / patients, carers and multi-disciplinary team document within. This will include an individualised care plan developed with the older person and their carer that can be taken home with them upon discharge.</p>	Year 1-2

Carers	Outcome: Exercise of Choice and Control	
Information	<p>6. Improved provision of information to older people / patients during their time in hospital with regards what to expect during their stay. This will include information regarding choice of care homes, continuing health care assessments, medication regime and available statutory and voluntary sector community services.</p> <p>Outcome: Exercise of Choice and Control</p>	Year 1-2
	<p>7. Testing out of a number of <i>transitional</i> beds aimed at supporting patients who when in hospital feel that their needs are such that they may require long term care (e.g. rest or nursing home).</p> <p>The aim of these transitional beds is to provide older people and their families with more time within a more suitable environment to make these significant life changing decisions so that once their confidence has returned, they may reconsider their decision to return home.</p> <p>People who previously were managing quite independently at home prior to their hospital admission will be targeted for this service.</p> <p>Outcome: Improved Quality of Life</p>	Year 1
Quality	<p>8. To develop key care pathways that specifically target clinical conditions that locally have longer lengths of stay that the national average to improve both patients experience and reduce length of stay in acute hospital.</p> <p>Outcome: Commissioning and use of Resources</p>	Year 1-3
	<p>9. Development of services that specifically support people who have had an orthopaedic operation (e.g. fixing of broken hip) and post operatively are unable to fully walk or weight bear to recuperate in the community or at home until they are fit enough for rehabilitation</p> <p>Outcome: Improved Quality of Life</p>	Year 1
	<p>10. To review the current local stroke care pathways and community and hospital stroke services against best practice and local need so that improvements can be identified and implemented across East Sussex. To include a review of the role of hospital rehabilitation and stroke wards, intermediate care units and community rehab and stroke teams.</p> <p>Outcome: Commissioning and use of Resources</p>	Year 1-2
	<p>11. Additional specialist support via a psychiatric liaison team in the assessment and care of older</p>	Year 1

	<p>people with mental health needs whilst in A&E, hospital ward or local intermediate care / community bed. The aim of this service will be to ensure that older people have both their mental and 'physical or clinical' health needs effectively met whilst in an acute or community/intermediate care hospital.</p> <p>The team will also provide specialist mental health training programmes for the staff within the hospitals focused on improving the care and experience of patients with mental health needs.</p> <p>Outcome: Commissioning and use of Resources</p>	
	<p>12. <i>Development of new intensive community support service for older people with mental health needs to enable the timely transfer home from acute mental health beds.</i></p>	Year 1
Carers / Information	<p>13. To explore further opportunities to support older people and their carers whilst in hospital with regards their medication. To include:</p> <ul style="list-style-type: none"> ▪ User friendly and simple information for patients and their carers whilst in hospital and upon discharge ▪ Taking own medication whilst in hospital ▪ Having trained volunteers support older people in hospital get confident with taking new medication regime ▪ Follow up from hospital from pharmacist or trained volunteer re medication <p>Outcome: Exercise of Choice and Control</p>	Year 2
	<p>14. Build on and further develop services and support for older people living alone to help address issues of reduced confidence and/or loneliness after hospital discharge.</p> <p>Outcome: Improved Quality of Life</p>	Year 2

6.3.5 In Need of Long Term Support

STAKEHOLDER HYPOTHESES	ACTIONS	PRIORITY / YEAR
Well Being	1. With partners, provide flexible range of services as alternatives to intensive services : <ul style="list-style-type: none"> • Develop the Well Being and Quality of Life strategic approach in order to secure access to a wider range of support within the community Outcome: Improved Quality of Life	Year 1–2
Carers	2. Ensure this strategy links with the Carers Services Commissioning Strategy: <ul style="list-style-type: none"> • Specify requirements for residential respite, systems for accessing and use of contracting arrangements • See specific recommendations within Carers Services Commissioning Strategy 2007 and Implementation Plan. Outcome: Leadership and Management	Year 1
Prevention	2. Increase the number of households per 1,000 of the population aged 65+ who are benefiting from intensive home care. Outcome: Personal Dignity and Respect	Year 1
Prevention	4. Make best use of the Preventive Technology Grant (PTG) over the next 2 years, evaluate and target future investment in Telecare: Outcome: Improved Quality of Life	Year 1 - 2
Joint Working	5. Work more closely with other agencies in the provision of assistance for people wishing to remain in their own homes: <ul style="list-style-type: none"> • Through locality based OP Housing & Support Groups – strengthen links with Home Improvement Agencies, Housing departments and others. • Working with planners in districts & boroughs to promote ‘Lifetime Homes Standards’ when developing new properties. • Investment in the ‘low level’ services such as gardening, shopping, handyman that promote mental and physical well being Outcome: Leadership and Management	Year 1
	6. Develop and begin implementation of a 3 year Strategic Plan for Direct Payments	Year 1

	<p>7. Re-focus the Supporting People budget to those in greatest need by breaking the link with tenure, increasing floating support, using telecare and promoting Extra Care housing</p> <p>Outcome: Commissioning and use of Resources</p>	Year 1 - 2
Quality	<p>8. Re-focus ESCC day care and other directly provided services (DPS):</p> <ul style="list-style-type: none"> • Through the DPS review process establish value for money and fit for purpose (in the light of the need for rehabilitation/intermediate care as well as longer term on-going support/respice) • Update and standardise the specification and contracts with voluntary sector providers of day care • Encourage a broader market provision of day care and day services with voluntary and independent providers • Broaden the range and flexibility of day services for older people including access to those services available to the whole community which can be used alongside day centres to promote social inclusion and independence • Provide services at weekends and outside of traditional day centre core programme times <p>Outcome: Commissioning and use of Resources</p>	
Joint Working	<p>9. Raise the profile and partnership working between housing departments, Supporting People, PCT's and Adult Social care and other partners:</p> <ul style="list-style-type: none"> • Implement the Action Plans emerging from the Locality Based Older People Housing & Support Strategies • Develop an East Sussex OP Housing & Support Strategy • Establish an 'Extra Care Select List' of partner agencies for the development of Extra Care in response to bidding and development opportunities (for build and service elements) <p>Outcome: Leadership and Management</p>	Year 1
	<p>10. <i>Seek funding and development opportunities to increase the level of Extra Care housing provided across the county:</i></p> <ul style="list-style-type: none"> • <i>Peacehaven Extra Care scheme to be developed over next 2 years in partnership with RSL</i> • <i>Promote mixed tenure Extra Care Housing</i> • <i>Work with private developers, planners and housing departments to achieve strategic development of supported housing</i> 	Year 1 - 2

<p>Joint Working</p>	<ul style="list-style-type: none"> • <i>Work with partners to bid against Housing Corporation Funds to secure capital for the development of Extra Care Schemes</i> • <i>Improve the quality and accessibility of information for people considering moving to supported accommodation (sheltered housing, extra care housing) in order to promote choice and control</i> <p>Outcome: Commissioning and use of Resources</p>	
<p>Quality</p>	<p>11. Effectively manage the Residential Care Home and Home Care markets by introducing:</p> <ul style="list-style-type: none"> • New contracting and service specification arrangements with independent providers • Balancing equity, Value for Money and sustainability • New technology to reduce overheads in order to release funds for care services • Exploring opportunities for joint procurement and contracting between health and social services <p>Outcome: Personal Dignity and Respect</p>	<p>Year 1</p>
<p>Joint Working</p>	<p>12. Develop modernised needs led residential services in partnership with PCT's:</p> <ul style="list-style-type: none"> • Jointly develop service models for the re-commissioning of residential services through the 'Age Well' PFI project, with specific emphasis on the needs of older people with mental health problems • Provide locally accessible resources in four establishments providing a total of 188 beds and at least 63 places for day therapy outreach and consulting <p>Outcome: Commissioning and use of Resources</p>	<p>Year 1 - 2</p>