

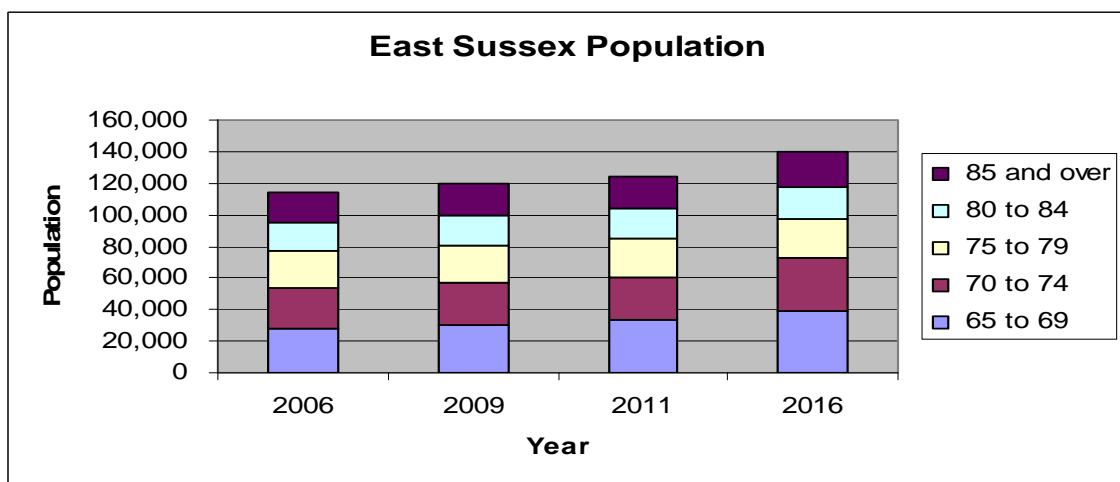
Joint Older People's Commissioning Strategy

Executive summary

Introduction

This strategy describes how health, social care and supported-housing services (also known as sheltered housing) 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 together to improve the experience of those who use them, and to get the most out of available resources.

The population of East Sussex is changing and, in the future, more people will be living longer. This is shown in the graph below.



Health care, social care and housing services have to respond to these changes and this strategy is one of the main ways to achieve this.

The strategy is based on:

- an assessment of older people's needs;
- a review of models of best practice;
- how well our existing services are performing; and
- what our patients, people who use our services and our partners have told us.

The focus of this strategy is on preventing and promoting health and wellbeing by providing more care closer to home, in line with national policies.

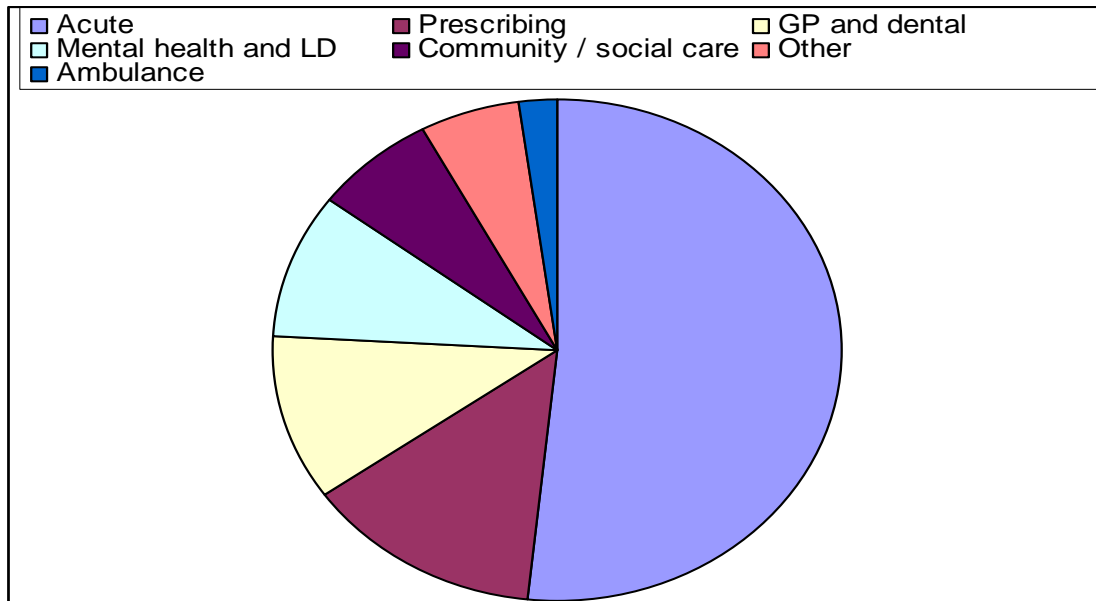
It is important that we are open in everything we do and that we work with our local partners to make the best use of limited resources as well as improve the lives of local people. We are already working well with voluntary sector organisations such as Age Concern and we regularly consult our partners (Housing Departments for example).

We will develop new sorts of 'care pathways' in the future, which will mean giving older people advice about how to stay physically and mentally healthy

and by supporting them so that they can look after themselves. Older people who are at risk from certain health problems like falls or dementia, will benefit from this kind of support as it will prevent (or at least delay) them from developing health problems that could lead to them going into hospital or a care home, which are where most of our money is currently spent.

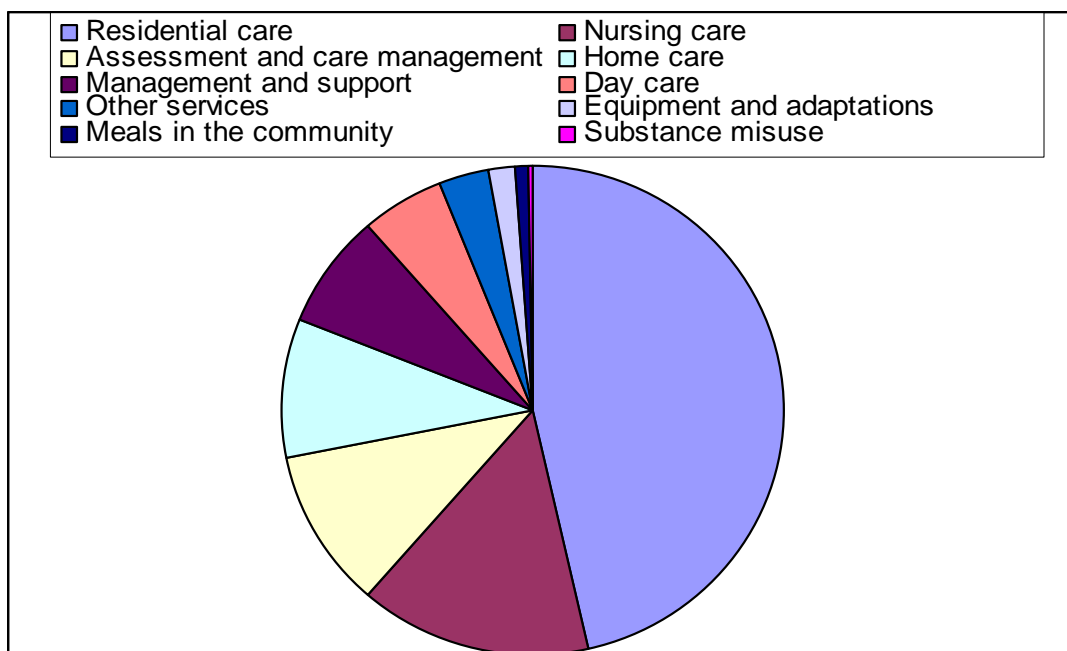
This is shown in the following pie charts.

NHS Primary Care Trust (PCT) spending in 2005 to 2006



(Information provided by the East Sussex LHC Sustainability and Integrated Service Improvement Plan.)

Spending on adult social care in 2005 to 2006



In East Sussex we have a higher than average number of older people (aged 65 and over) living here and this number is set to increase in the future. Over the next 10 years in particular, demand for existing services will increase sharply. At the same time, costs will rise and we will not be able to afford to provide these services in the longer term.

We have an opportunity, before then, to reduce the number of older people who go into hospital and residential care. As we know what problems are most likely to affect older people, we can target our resources towards meeting those particular needs.

For example, older people often need long-term health, social-care and residential services after:

- a fall;
- a stroke;
- one of a number of chest or breathing (respiratory) complaints (for example, chronic obstructive pulmonary disease or COPD); or
- dementia.

If we could do more to prevent these problems in the first place, and to improve the treatment and care of older people if these problems do occur, this would be better for everyone.

In the future, we will co-ordinate or jointly 'manage' care for older people between health-care and social-care providers, so that a range of services will be able to respond to emergencies quickly and in line with how serious they are. This will create opportunities for putting long-term support in place, which will offer the best chance of recovery and avoid a stay in hospital.

The main developments in this strategy

The strategy sets out a wide range of proposals for change, which relate to the different stages in their lives at which older people need to use health and social services or residential care.

It is vital that health-care and social-care staff improve the way they work together and how they manage the care and treatment they provide. If we offer those people receiving services the opportunities to make more choices and take more control of their own care, it will also help them to stay independent. This will be one of the first main developments we will put into practice, together with looking at how we can work with our partners to target our shared resources such as staff or services.

Improving local intermediate care services to make sure they meet local need will be a priority. These services try to prevent older people having to go into hospital or care homes. For those people already in hospital or a care home, these intermediate care services help to get them back home by giving them the support they need to recover at home.

Primary care (for example, GPs) will continue to play a vital role in improving local care services aimed at preventing older people having to go into hospital or care homes. Services should improve the quality of life for older people in the future by looking beyond those provided by health, social care and housing.

Ongoing support for older people will also become increasingly important as they are living longer, and so the main developments in this strategy will include:

- more intensive home care being available in the future; and
- sheltered-housing schemes and extra-care housing schemes (providing on-site 24 hour care and support) that will help support older people living in their own homes for as long as possible.

Supporting older people in their own homes will also mean that they can stay in their community and continue taking an active role in local activities.

Housing-related support will become more flexible as it reduces its link to sheltered-housing schemes and is linked to an individual's need. More extra-care housing is planned in the future. If you or a relative or friend needed to move into a care home, we would help you to find an appropriate place. By maintaining the standards of quality care provided in these settings, we and our partners will allow older people to keep their dignity. We will also improve the pain relief and other care that older people nearing the end of their lives receive.

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 improvements in the future.

Falls – Falls can seriously affect the physical and mental health of older people, and can reduce their independence. The risk of falling is reduced by:

- GPs reviewing the medication that patients are on (in case any of it could make them drowsy and so more likely to fall);
- removing dangers from the person's home (for example, using a stair lift or a walk-in shower); and
- taking exercise classes (under supervision).

Ambulance crews have been trained to treat minor injuries in the home to avoid having to take the patient to hospital, and also to provide help for those who fall at home to get them upright and to make sure there are no serious injuries.

We have specialist teams who assess those older people who have been referred to them as being at risk of falling in the future, and provide care and treatment to meet their needs. These teams will work more consistently across East Sussex in the future.

Stroke – Healthier lifestyles (diet and exercise) and prescriptions from GPs can reduce the risk of first and future strokes. Specialist care in hospitals and from community rehabilitation teams is known to improve outcomes for stroke patients, and these will be better co-ordinated and provided more consistently across East Sussex in the future.

Chest or breathing (respiratory) diseases, including chronic obstructive pulmonary disease (COPD) – Help with stopping smoking is the best way to prevent COPD or to reduce its seriousness. Specialist teams that can support patients to manage their COPD can prevent serious attacks of the disease that would currently mean the patient would have to go into hospital. We will review how we manage our services to support this particular group.

Dementia – As the causes of dementia are not known, it cannot be prevented. But, care services can and do provide information and support to help sufferers and their families to cope with its effects, and we are trying out an early-intervention service that identifies symptoms and works with people experiencing the early stages of dementia. Community mental-health teams provide ongoing support for people who suffer from depression as well as dementia, and can provide intensive support at home to prevent the patient having to go into hospital, which could itself increase their confusion.

We will refurbish and improve inpatient units for older people with mental-health problems and we have already introduced a new service to support older people admitted to acute hospitals who also have mental-health problems. We have similar developments planned to support mainstream rehabilitation and intermediate-care services. We will also take into account the needs of people with dementia when we are designing and developing new extra-care housing schemes.

Complex needs – Healthier lifestyles are encouraged by GPs and by funding voluntary-sector services that promote health and wellbeing particularly for those people who experience more than one long term health condition and regularly use health services.

Community-health and social-care staff assess the needs of older people who are most at risk of a hospital admission or residential care and manage their care to prevent their health getting worse. We will reduce the length of time that older people have to wait to be assessed and provided with the services they need. We will also focus on more personalised care and better outcomes for older people, and encourage them to take more control in organising their own care.

Delivering the strategy

We will tackle strategic developments in the order of the costs and benefits they will deliver in order to provide value for money. As care providers, the primary care trust and adult social-care services have identified which areas of priority they will invest in. We will need to make sure that both organisations

have the resources they need, and that health-care and social-care providers continue to work with other agencies to deliver their services.

We have prepared a series of action plans that set out in detail how we will bring about the changes we want to see, and we have put arrangements in place to oversee progress and to guarantee that we account for our actions. These include a Joint Executive Group of Chief Officers from health and social-care organisations and a Whole System Leadership Group of senior managers will make improvements across organisations.

We have set up a Partnership Board for Older People which includes members from health, social-care and housing organisations, and the voluntary sector and representatives from local older people's forums. There are already a number of subgroups responsible for our action plans, and more will be created if required to ensure that the strategy is effectively implemented.

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 groups plan to increase their investment over the next three years to support our main strategic developments and to tackle the main problems that affect older people.

Investment plans for the NHS and primary care trusts to 2009-2010

Service development (investment running total) [See note 1 below]	2007-2008 £	2008-2009 £	2009-2010 £
Improved team in A&E and MAU (Medical Assessment Unit)	200,000	350,000	580,000
Community intermediate care	0	100,000	200,000
STAN (Single Telephone Access Number)	220,000	250,000	250,000
Falls service	325,000	529,000	575,000
COPD (chronic obstructive pulmonary disease)	0	189,000	189,000
Heart failure	46,000	121,000	150,000

Investment plans for adult social-care services to 2009-2010

Service area 2007-2008 (investment running total) [See note 2 below]	2007-2008 £	2008-2009 £	2009-2010 £
Assessment and care management	374,000	973,000	148,00
Nursing care	721,000	1,085,000	1,137,000
Residential care	1,428,000	956,000	1,430,000
Home care	302,000	365,000	451,000
Day care	97,000	(45,000)	(100,000)
Meals in the community	22,000	20,000	20,000
Other services	18,000	29,000	27,000

Note 1: does not include inflation.

Note 2: does include inflation.

Risks

The risks associated with this strategy relate to how effective the partnership between health, housing and adult social care is, and the significant changes that we will need to make to implement the action plans.

The main risks in introducing the strategy are as follows.

- Working with our partners to improve services within East Sussex will be vital. Improvements in the way health, housing and social-care services are co-ordinated are essential as they all depend on each other. If we are going to continue improving the services for older people in East Sussex, we need to continue developing more effective ways of working together.
- Although we have been careful not to overestimate the budgets and specific grants we (health and adult social care) receive from the Government, if they withdrew all or part of any of our specific grants this would put our financial planning at risk.
- To deliver this strategy, we and our partners will need to introduce many changes to the way we work. For this reason, we need to manage this programme effectively as a whole, as well as making sure we have enough managers in place to deliver the strategy's aims.
- Although the strategy provides a clear direction and specific actions, our partner organisations will need to welcome and introduce changes in policy and law.
- Delivering improvements to services will, of course, mean changes for people who currently provide and receive services, and these changes may not always be popular. If this strategy is to be introduced successfully, it will depend on how well we and our partners manage these changes for staff and those people receiving our services.

Equality

Although the strategy focuses on the needs of the general population of older people in East Sussex, we know that there are specific groups of people within that community who have extra needs such as:

- those from black and minority-ethnic (BME) groups; and
- those whose culture or lifestyle affects their health, social care or housing needs (for example, gypsies and travellers).

We have already made good progress in completing an Equalities Impact Assessment on the strategy. This looks at how our plans affect specific groups in relation to the changes we are proposing. We will discuss this assessment with our partners in a series of events during the autumn. We have already noted in our action plans the need to tackle any issues arising from these events, and we will continue to assess and tackle these issues while we are introducing the strategy.

Conclusions

This is a three-year strategy. We will monitor, review and, if necessary, change the way we are introducing this strategy, by consulting a wide range of our partners, including those who use the services. The strategy is the guide to how we will deliver improved services for older people in East Sussex. It represents a significant development in the partnership between health, social care and housing and their commitment to work with other agencies in improving the physical and mental health and wellbeing of older people in East Sussex.

Action plans

We have set out in a series of action plans what we will do over the next three years to deliver the aims and objectives of our strategy. These action plans are based on the following aims that came out of the various discussion events we held while we were developing this strategy. People were asked to suggest what we needed to do in order to improve the way we deliver services for older people.

Aims

- **Joint working** - Improved communication and co-operation between health and social care and other organisations will mean improved services for older people.
- **Prevention** - If we invest in home-care services, community nursing and rehabilitation (helping people to recover through treatment and advice), more people will be able to stay at home instead of going into residential care.
- **Wellbeing** - If we took a longer-term view of preventing illness or falls where possible, looking after older people's wellbeing and allowing them to make their own decisions, this would help older people to have a better quality of life and a more positive experience of old age.
- **Information** - If we provided more information about the available services, older people would be able to take control of their own lives by making informed decision.
- **Carers** - Investing in services for carers will save money, as carers do not charge for their services. The alternative would be much more expensive.
- **Equality** - We will be better able to achieve equality by being flexible in the types of services we offer and sensitive to people's lifestyles and where they live.
- **Quality** – Our services will be more effective if we develop and deliver them in line with clear standards of quality and cost.

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

Outcomes from the White Paper

'Our health, our care, our say: A new direction for community services'

- **Improved health:** older people are entitled to enjoy good physical and mental health (including being protected from abuse and being treated fairly). Older people are entitled to access to appropriate treatment and support so that they can cope with long-term conditions while still living at home (such as assistance with taking medication). There should be opportunities for (supervised) physical activity.
- **Improved quality of life:** older people should have access to leisure, social activities and lifelong learning and to all public and commercial services (such as private leisure centres or clubs). Older people should also feel safe in their own homes, have access to public transport and be confident of their safety outside their homes.
- **Making a positive contribution:** older people should be encouraged to be involved in their local community through employment or voluntary work, and get involved in our policy-development and decision-making processes.
- **Making choices and taking control:** through greater independence and access to information. Older people should be able to choose and control the services they need to help them manage risk in their personal life.
- **Freedom from discrimination or harassment:** older people should all have equal access to services. They should not be the victims of abuse of any kind.
- **Economic wellbeing:** older people should have enough income to afford a good diet, their living costs and to be able to take part in family and community life. They should also be able to meet the costs of their own particular needs – such as paying for home care.
- **Personal dignity and respect:** if they need it, older people should have help with their personal care so that they and their homes are clean and comfortable.

Commission for Social Care Inspection (CSCI) – have added two further outcomes

- **Inspecting for better lives: a quality future**

Leadership and management: People experience services that are well led. There are clear plans for now and the future.

- **A new outcomes framework for performance assessment of adult social care**

Commissioning and use of resources: Adult social-care services are delivered to clear standards of quality and cost, as effectively, economically and efficiently as possible.

When we start introducing the action plans shown on the next few pages, we will be developing in more detail what each of them will involve for us, who will be responsible for taking them forward, and within what timescales.

We will then monitor these plans and our progress against them through the management and accountability arrangements described in more detail in the full strategy. By 'accountability', we mean taking responsibility for our actions and being able to answer for them.

1. Fit and well and growing older

Actions	Timescale
<p>1 Decide how to complete a 10 to 15 year joint strategic needs assessment (JSNA) between health and social care, looking at the health needs of the whole population of East Sussex.</p> <p>Aims: Quality Outcome: Delivering care and using resources</p>	<p>Year 1</p>
<p>2 Develop a strategy for promoting and improving the health and wellbeing of older people that focuses on the main priority areas in:</p> <ul style="list-style-type: none"> • tackling health inequalities; (there are differences in the health of communities across East Sussex) • reducing smoking; • tackling obesity; • improving sexual health, mental health and wellbeing; • reducing harm as a result of abuse; and • encouraging sensible drinking <p>Aims: Prevention Outcome: Improved health</p>	<p>Years 1 to 2</p>

<p>3 By continuing to develop the local area agreement, build greater co-operation within the East Sussex Strategic Partnership to improve the health and wellbeing of older people in East Sussex and to reduce health inequalities within the county. The main priorities will be to:</p> <ul style="list-style-type: none"> • promote physical and mental wellbeing, including reducing falls, reducing early deaths 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 older people's income; • improve independence, wellbeing and choice, including setting up a referral system so that individuals can set support from all the appropriate agencies through staff on a central contact number; and • improve the experiences of users, patient and carers in using our services. <p>Aims: Wellbeing Outcome: Improved quality of life</p>	<p>Years 1 to 2</p>
<p>4 Providing 'health checks' which include:</p> <ul style="list-style-type: none"> • improved information and access to a range of health-check services including eye tests; and • training for staff on preventing illness and accidents and promoting health in a range of settings including voluntary-sector day care and other groups where older people meet. <p>Aims: Prevention Outcome: Making choices and taking control</p>	<p>Year 1</p>
<p>5 Promoting 'active aging' schemes, for example:</p> <ul style="list-style-type: none"> • building on the achievements of 'Active Hastings' which promote physical activity as a way of staying healthy; and • promoting quality of life with older people's forums. <p>Aims: Wellbeing Outcome: Improved quality of life</p>	<p>Year 1</p>

<p>6 Respond to the recommendations of the scrutiny committee review of preventative services that help people to keep their independence.</p> <p>Aims: Prevention Outcome: Leadership and management</p>	<p>Year 1</p>
<p>7 Continue to introduce and develop the older people's involvement strategy to encourage older people to get involved in the community and in policy development and decision making by:</p> <ul style="list-style-type: none"> • increasing the number of older people involved in their local older people's forum; • developing the Older People's Partnership Board; • developing a co-ordinated approach among all our departments to older people's priorities by setting up the older people's working group; and • developing our future approach to improving wellbeing and quality of life for older people, which will include the priorities identified by local older people themselves and the Adult Social Care Department's future direction (as reflected in this strategy). <p>Aims: Joint working Outcome: Making a positive contribution</p>	<p>Years 1 to 3</p>
<p>8 Working closely with the voluntary sector to provide preventative services and social opportunities to:</p> <ul style="list-style-type: none"> • make sure that, over time, contracts are better suited to the priorities needed and focused on outcomes; • contract with the voluntary and community sector (VCS) to provide those services we used to provide ourselves; and • support the arrangements that are in place for working with the (VCS). <p>Aims: Joint working Outcome: Delivering care and using resources</p>	<p>Year 1</p>

<p>9 To improve access to simple aids and equipment to help older people continue to live at home, we will:</p> <ul style="list-style-type: none"> • revise our assessments of people's needs to include by phone and internet to speed up and simplify the process; • provide better information about how older people can get hold of this equipment; and • make sure we can cope with any increased demand as a result of this easier access. <p>Aims: Information Outcome: Improved quality of life</p>	<p>Year 1</p>
<p>10 Reduce the time it takes to arrange an assessment of an older person's needs.</p> <ul style="list-style-type: none"> • Our aim is to increase the proportion of people who have an acceptable waiting time for their assessment from 55% now to 90% by 2009-2010). The national indicator for Adult Social Care regards acceptable as beginning within 48 hours of first contact) <p>Aims: Quality Outcome: Leadership and management</p>	<p>Year 1</p>
<p>11 To improve the focus on older people with mental-health needs, particularly dementia, we will:</p> <ul style="list-style-type: none"> • test and assess a memory assessment and support team (MAST) service; and • train staff to identify and respond to the early signs of dementia. <p>Aims: Quality Outcome: Improved health</p>	<p>Year 1 to 2</p>
<p>12 We will tackle any issues arising from the consultation events taking place in the summer on the 'equalities impact assessment' (EIA) of the strategy. This looks at the particular impact of the strategy on people from diverse groups within the population, such as those from religious or cultural minority groups but also those with particular disabilities.</p> <p>13 The detail of the plan to introduce the strategy will mean that issues of equality are identified and dealt with.</p> <p>Aims: Equality Outcome: No-one is harassed or discriminated against</p>	<p>Year 1</p>

2. Problems that could be prevented

Actions	Timescale
<p>1 Develop plans to combine the two community mental-health teams (CMHTs) for older people with the two primary care trust (PCT) teams to improve efficiency, response times and patient care.</p> <p>Aims: Joint working Outcome: Providing services and using resources</p>	<p>Year 2</p>
<p>2 To develop and provide information for older people and their carers on how to look after themselves and what facilities and services are available to them in the local community, including housing-related grants (for example, to help pay for damp-proofing) and help with meeting costs of other improvements such as rails to help with mobility. We will provide information in a range of different formats including in leaflets, in posters, on video, by phone and on the internet.</p> <p>Aims: Information Outcome: Making choices and taking control</p>	<p>Year 2</p>
<p>3 Review how we can simplify information about how older people can get access to services so that it is simple, clear and consistent for local people and their carers to understand.</p> <p>Aims: Equality Outcome: Improved health</p>	<p>Years 1 to 2</p>
<p>4 To develop a range of preventative services as part of the wider aim to prevent illness, accidents and so on. For example, older people will be advised on how to build their confidence, deal with loneliness and isolation, use Telecare, and look after themselves. Telecare is the use of equipment that can detect changes in a home (such as falls, temperature, water) so that assistance can be provided. This allows people to remain at home safely.</p> <p>Aims: Prevention Outcome: Improved quality of life</p>	<p>Years 1 to 3</p>

<p>5 Develop a system of care throughout East Sussex for patients with chronic (long-term) disease such as heart disease or diabetes. This system of care will include:</p> <ul style="list-style-type: none"> ▪ information and support to help the patient manage their disease (including expert patients' and carers' programmes); and ▪ intensive support for patients with complicated needs. <p>Aims: Joint working Outcome: Making choices and taking control</p>	<p>Years 2 to 3</p>
<p>6 Review the current methods used to identify patients at risk of getting worse or having to go into hospital as a result of chronic (long-term) disease, and to make sure that these methods are consistent across East Sussex.</p> <p>Aims: Prevention Outcome: Making choices and taking control</p>	<p>Years 1 to 2</p>
<p>7 Make sure the older person is assessed as an individual and that they can make choices about their own care. Encourage staff to get the older person's permission as part of this single assessment process (SAP) so that they are part of the ongoing process to review and monitor the care that is provided.</p> <p>Outcome: Making choices and taking control</p>	<p>Years 1 to 3</p>
<p>8 Make sure that by April 2008 all patients with complicated and chronic (long-term) diseases have their own personal care plan. We will continue to use the single assessment process and targets so that we can assess a person once rather than a number of times, and then share the information with the appropriate health and social-care agencies.</p> <p>Outcome: Making choices and taking control</p>	<p>Years 1 to 2</p>
<p>9 Review ways in which we can improve the care-management process for older people.</p>	<p>Years 1 to 2</p>

<p>10 Review the role of community matrons to include:</p> <ul style="list-style-type: none"> ▪ how risks to patients are identified; ▪ how patients are assessed and cared for – balance between new assessments and ongoing case management; ▪ case management for patients who go into hospital (A&E and on a ward); and ▪ response times and action taken, seven days a week. 	<p>Years 1 to 2</p>
<p>11 To promote and explain the role of specialist nurses and community matrons to patients, carers and staff.</p>	<p>Years 1 to 2</p>
<p>12 Explore opportunities and test out ways for health and adult social-care services to work together to manage care for people with complicated needs or chronic (long-term) disease (or both). The following are some examples of how we will do this.</p> <ul style="list-style-type: none"> ▪ Develop approaches where there is one case manager for each patient, no matter what organisation they are from and who will be responsible for supporting and helping that patient and their carer, and for working with all other organisations involved with their care. ▪ Test out locally-based joint case-management teams who identify those people in their area at risk of needing hospital care and work together to manage the care of these patients together. The case-management team could include community and specialist nurses, community matrons, social workers, therapists, pharmacists and GPs. ▪ Consider using the law to support joint working, for example section 31 of the Health Act 1999 (Health Act Flexibilities). <p>Aims: Joint working Outcome: Leadership and management</p>	<p>Years 1 to 2</p>
<p>13 To further develop plans to support older or vulnerable people in the community who have many different medicines to take each day, or who have to keep changing their medicines (especially patients who have recently come out of hospital) and to include the role of local pharmacists and new pharmacists' NHS contracts. These allow local pharmacists to provide additional services such as health checks.</p> <p>Outcome: Making choices and taking control</p>	<p>Year 2</p>

<p>14 Develop health-promotion activities for older people at risk from strokes and falls, to include:</p> <ul style="list-style-type: none"> ▪ promoting healthy lifestyles; ▪ advice about a healthy diet and watching their weight; ▪ advice to help them stop smoking; and ▪ exercise classes. <p>Aims: Wellbeing Outcome: Improved health</p>	<p>Years 1 to 2</p>
<p>15 Develop and introduce a care system for patients with chest and breathing (respiratory) diseases such as chronic obstructive pulmonary disease (COPD) and services that follow national best practice and local needs.</p> <p>Aims: Quality Outcome: Improved health</p>	<p>Years 2 to 3</p>
<p>16. Review day services for older people with mental-health needs so that we can provide these services closer to people's homes and target them to specific conditions, for example dementia or depression.</p> <p>Aims: Equality Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>
<p>17 Develop and improve mental-health services for older people in their own homes rather than in hospital. This will involve transferring resources from expensive bed based care to home-based services. Reduce current bed-based services from four units to two units – one for each primary care trust (PCT) area, in line with planned community mental-health teams (CMHTs).</p> <p>Aims: Quality Outcome: Personal dignity and respect</p>	<p>Years 2 to 3</p>

<p>18 Look into the possibility of a service for older people with 'challenging behaviour' such as being physically or verbally abusive to a carer. The plan is for eight inpatient beds (for crisis and respite (recovery) care) and specialist assessment and outreach teams to support older people with extremely challenging behaviour and their carers to manage as independently as possible at home.</p> <p>Outcome: Personal dignity and respect</p>	<p>Years 2 to 3</p>
<p>19 To improve support for those who pay for their own social-care services so that they get the same levels of information and advice as those who don't pay for their care.</p> <p>Aims: Information Outcome: Economic wellbeing</p>	<p>Years 1 to 3</p>

3. In immediate need of help or treatment

Actions	Timescale
<p>1 To continually review information from the single telephone access number (STAN) to identify those medical conditions that we could manage safely and effectively within the community if there were the appropriate care services in place and to develop care services that can prevent older people having to go into hospital when it could have been avoided. By using the STAN number we are able to see who uses the service and what medical conditions they have.</p> <p>Aims: Prevention Outcome: Leadership and management</p>	<p>Year 1</p>
<p>2 Make sure we make best use of existing community-based services and aim to increase direct admissions from community and STAN to prevent older people having to go into hospital when it could have been avoided.</p>	<p>Years 1 to 3</p>
<p>3 Make sure all appropriate community services are informed and respond quickly when patients whose cases they manage arrive in the emergency-care department (for example community matrons, specialist nurses and community mental-health teams). These teams should contact the older person, their carer and their hospital worker to help the older person get back into their own home as soon as they are able to leave hospital.</p> <p>Aims: Carers Outcome: Improved health</p>	<p>Years 1 to 2</p>
<p>4 Look into whether community staff who work out of hours (for example, community nurses, GPs and emergency care practitioners ECPS) can be based together in the emergency-care department to help prevent older people coming to A&E or coming into hospital.</p> <p>Aims: Joint working Outcome: Leadership and management</p>	<p>Years 1 to 2</p>

<p>5 Review the current systems of care within the emergency-care department and how the various members of the team work together to assess and support older people. This review will include older people with mental-health needs arriving at hospital as an emergency, with the aim being to get them sent home from A&E as soon as they are well enough. Explore opportunities for experienced medical leadership of Medical Discharge Team in A&E.</p> <p>Aims: Joint working Outcome: Leadership and management</p>	<p>Years 1 to 2</p>
<p>6 Carry out a review of why older people are coming into A&E so that we can identify how we can manage some of these people more effectively at home rather than in hospital.</p> <p>Aims: Prevention Outcome: Leadership and management</p>	<p>Years 1 to 2</p>
<p>7 Develop services and schemes that identify and provide support for carers to help prevent older people being sent into hospital when it could have been avoided (a joint carers' strategy has been written for East Sussex and is available on request from the contact details below).</p> <p>Aims: Carers</p>	<p>Years 1 to 2</p>
<p>8 Provide older people and carers with user-friendly information about alternatives to A&E and going into hospital. To develop this information in consultation with older people's forums and user groups. Information to be provided by places that older people often use, for example GP surgeries, libraries and user groups.</p> <p>Aims: Information Aims: Carers Outcome: Making choices and taking control</p>	<p>Years 1 to 2</p>
<p>9 Look at how we can develop 'phone before you go' for patients as a local alternative to A&E. This will give older people and their carer's alternative options for care other than A&E by providing information on services such as GP or pharmacy.</p> <p>Aims: Equality Outcome: Making choices and taking control</p>	<p>Years 2 to 3</p>

<p>10 Review current intermediate care services including beds for rehabilitation and respite care, and develop an intermediate care strategy to serve the whole of East Sussex. This strategy will include:</p> <ul style="list-style-type: none"> ▪ joint definition of those services to be included in intermediate care; ▪ as part of developing intermediate care services that are not based in community beds (for example, rapid-response care at home and using day hospitals); ▪ a single assessment process (including shared information and the technology that supports this); ▪ joint training and workforce opportunities; ▪ specialist input from mental-health experts; ▪ GPs or consultants taking the lead within intermediate care services but still working as part of a team; and ▪ using intermediate care units and community hospitals as a point of contact for joint teams and local voluntary groups. <p>Aims: Joint working Outcome: Improved health</p>	<p>Year 1</p>
<p>11 Review how effective the current rapid-access clinics for stroke patients are, as part of the review of the stroke-care system to identify improvements that can be made.</p> <p>Outcome: Providing services and using resources</p>	<p>Year 1</p>
<p>12 Develop and put in place care systems and a strategy across East Sussex to deal with older people who have had a fall. The strategy will include the following.</p> <ul style="list-style-type: none"> ▪ A review of assistance services for falls particularly the ('man with a van' service which). It will depend on the outcome of this review whether the service will continue. ▪ A review of the Emergency Care Practitioner Falls Service. It will depend on the outcome of this review whether the service will continue. ▪ Continually reviewing and improving current services for falls across East Sussex. <p>Outcome: Improved health</p>	<p>Years 1 to 2</p>

<p>13 Assess the new intensive community-support service for older people with mental-health needs. This service provides intensive support for older people with mental-health needs in their own home to prevent them having to go into hospital when it could have been avoided.</p> <p>Aims: Prevention Outcome: Providing services and using resources</p>	<p>Year 1</p>
<p>14 Rearrange inpatient mental-health services to provide fewer and more specialist facilities and to invest more in community-based services.</p> <p>Aims: Equality Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>
<p>15 Review the effectiveness of the 'navigator' service which helps people to locate services in their local community and make recommendations for improvements.</p>	<p>Year 1</p>

4. Ready to go home

Actions	Timescale
<p>1 Improve planning processes for when hospitals send patients home. These improvements will include the following.</p> <ul style="list-style-type: none"> ▪ Developing a policy of choice across East Sussex that will be supported by a training programme for staff and patients. ▪ Being consistent in deciding where free nursing care should be applied, which includes improving information we provide for patients, their carers and social care, and involving them more in making decisions. ▪ Being consistent in applying continuing health care, which includes improving the information we provide for patients, their carers and social care, and involving them more in making decisions. ▪ Developing clear systems of care and assessment for people in hospital who will need housing support. ▪ Identifying and managing care for people who are likely to have to stay in hospital for a long time while they are recovering from an operation, a medical condition or complicated needs. ▪ Training and support for the hospital teams (staff and doctors from the agencies involved in planning to send patients home) to use best practice in the acute and community hospitals to improve the experiences of all patients. <p>Outcome: Leadership and management</p>	<p>Years 1 to 2</p>
<p>2 Develop plans to increase the number of people sent home from hospital at the weekend. This will include a review of staff working seven days a week.</p> <p>Outcome: Improved quality of life</p>	<p>Year 1</p>
<p>3 Review whether we can make better use of 'discharge lounges'. These are areas where patients can wait for a lift home without having to still be on the ward when they no longer need to be on a ward. Develop patient information leaflets to explain the role of discharge lounges in increasing the number of people who are sent home from hospital in the mornings.</p> <p>Aims: Information Outcome: Improved quality of life</p>	<p>Year 1</p>

<p>4 Understand and consider transport issues that could delay a patient being sent home from hospital.</p>	<p>Year 1</p>
<p>5 Developing a hospital-discharge record. This is a record that the patients keep and that they, their carers and members of the hospital team all write comments in. This will include an individual care plan that care staff developed with the older person and their carer, and that they can take home when they leave hospital.</p> <p>Aims: Carers Outcome: Making choices and taking control</p>	<p>Years 1 to 2</p>
<p>6 Provide more and better information for older people and patients during their time in hospital to tell them what to expect during their stay. This will include information about their choice of care homes, continuing health-care assessments, the medicine they have to take, and which community services are available for them.</p> <p>Aims: Information Outcome: Making choices and taking control</p>	<p>Years 1 to 2</p>
<p>7 Testing a number of 'transitional' beds aimed at supporting patients who, when they are in hospital, decide that they won't be able to manage their own home and will need long-term care (for example in a rest home or nursing home).</p> <p>The aim of these transitional beds is to provide older people and their families with more time, in a more suitable environment outside of the hospital, to make these important decisions about their future so that once they are more confident, they may reconsider their decision to return home.</p> <p>We will target this service at people who were managing quite independently at home before going into hospital.</p> <p>Outcome: Improved quality of life</p>	<p>Year 1</p>
<p>8 To develop care procedures specifically for medical conditions that local people tend to be in hospital for longer than the national average, with the aim of improving patients' experiences and reducing the length of time they have to stay in hospital.</p> <p>Aims: Quality Outcome: Providing services and using resources</p>	<p>Years 1 to 3</p>

<p>9 Developing services that specifically support people who have had an orthopaedic operation (for example a hip replacement) and, after their operation, cannot walk properly or put their full weight on their hip, so that they can recover in community care or at home (until they are fit enough for physiotherapy and so on to help them recover).</p> <p>Outcome: Improved quality of life</p>	<p>Year 1</p>
<p>10 To compare the current local, community and hospital stroke services with best practice and local need so that we can identify improvements and introduce them across East Sussex. To review the role of hospital rehabilitation and stroke wards, intermediate care units and community rehabilitation and stroke teams – all of which help the stroke patient to recover and learn how to look after themselves at home again.</p> <p>Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>
<p>11 Further specialist support from a psychiatric liaison team who will assess and care for older people with mental-health needs while they are in A&E, on a hospital ward or in local intermediate care or a community-care bed. The aim of this service will be to make sure that older people have their mental-health needs and their physical or medical needs met while they are in an acute, community or intermediate care hospital.</p> <p>The team will also provide specialist mental-health training programmes for hospital staff which will focus on improving the care and experience of patients with mental-health needs.</p> <p>Outcome: Providing services and using resources</p>	<p>Year 1</p>
<p>12 Developing new and intensive community-support services for older people with mental-health needs to make sure they are transferred back home from acute mental-health hospital, as soon as appropriate.</p>	<p>Year 1</p>

<p>13 To look for more opportunities to support older people and their carers with their medication while they are in hospital. These opportunities will include:</p> <ul style="list-style-type: none"> ▪ user-friendly and simple information for patients and their carers while they are in hospital and when they leave hospital; ▪ the patient taking their own medication while they are in hospital; ▪ having trained volunteers to support older people in hospital and increase their confidence in taking new medication; and ▪ a follow-up system provided by a pharmacist or trained volunteer to help the older person with their medication when they are back home. <p>Aims: Carers Aims: Information Outcome: Making choices and taking control</p>	<p>Year 2</p>
<p>14 Build on and improve services and support for older people living alone to help tackle the issues of reduced confidence or loneliness after they have left hospital.</p> <p>Outcome: Improved quality of life</p>	<p>Year 2</p>

5. In need of long-term support

Actions	Timescale
<p>1 With our partners, we aim to provide a flexible range of services as alternatives to intensive home-care services. For example:</p> <ul style="list-style-type: none"> we will develop the 'wellbeing and quality of life' strategic approach to give older people access to a wider range of support within the community. <p>Aims: Wellbeing Outcome: Improved quality of life</p>	<p>Years 1 to 2</p>
<p>2 Make sure this strategy links with the Carers' Services Commissioning Strategy to:</p> <ul style="list-style-type: none"> identify the needs for residential respite care, systems for getting access to and use of services; and identify specific recommendations within the Carers' Services Commissioning Strategy 2007 and Implementation Plan. <p>Aims: Carers Outcome: Leadership and management</p>	<p>Year 1</p>
<p>3 Increase the number of households aged 65 and over (for every 1,000 of the population) who are benefiting from intensive home care.</p> <p>Aims: Prevention Outcome: Personal dignity and respect</p>	<p>Year 1</p>
<p>4 Make best use of the Preventive Technology Grant (PTG) – (this is a grant from central government that helps us provide new services such as falls sensors) over the next two years, and assess and target future investment in telecare.</p> <p>Aims: Prevention Outcome: Improved quality of life</p>	<p>Years 1 to 2</p>

<p>5 Work more closely with other agencies in providing help for people who want to stay in their own homes:</p> <ul style="list-style-type: none"> • through locally-based older peoples' housing and support groups, to strengthen links with home-improvement agencies, housing departments and others; • by working with district and borough planners to promote 'Lifetime Homes Standards' (these are new building standards that recommend door and corridor sizes so that adaptations are less likely to need to be made in the future) when they are developing new properties; and • by investing in low-level services such as gardening, shopping and someone to do odd jobs, all of which promote mental and physical wellbeing. <p>Aims: Joint working Outcome: Leadership and management</p>	<p>Year 1</p>
<p>6 Develop and begin a three-year strategic plan for direct payments – a system where people can make their own arrangements for their care rather than have it arranged by adult social care.</p>	<p>Year 1</p>
<p>7 Target the 'Supporting People' budget at those in greatest need this will involve providing support to individuals who need it, rather than to supported housing schemes. by breaking the link with sheltered housing, increasing more flexible ways of providing support, using telecare and promoting Extra Care housing.</p> <p>8 Supporting People provides housing related support to vulnerable people in the community.</p> <p>Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>

<p>9 Target East Sussex county council day care and other directly-provided services (DPS) by:</p> <ul style="list-style-type: none"> • using the directly provided services (DPS) review process to decide what is value for money and fit for purpose (in terms of the need for rehabilitation and intermediate care as well as longer-term, ongoing support and respite care); • updating and standardising the requirements and contracts with voluntary-sector providers of day care; • encouraging more voluntary and independent providers to provide day care and day services; • broadening the range and flexibility of day services for older people, including access to those services available to the whole community that older people can use alongside day centres to increase their independence and involvement in the community; and • providing services at weekends and outside the usual day-centre opening times. <p>Aims: Quality Outcome: Providing services and using resources</p>	
<p>10 Raise the profile of and work more closely with housing departments, Supporting People, primary care trusts, Adult Social Care and other partners to:</p> <ul style="list-style-type: none"> • introduce the action plans developed from the locally-based housing and support strategies for older people; • develop a housing and support strategy for older people in East Sussex; and • set up a list of extra-care providers so that we can develop extra-care services more quickly and in response to grants that are being offered (for buildings and services). <p>Aims: Joint working Outcome: Leadership and management</p>	<p>Year 1</p>

<p>11 Look for funding and development opportunities to increase the level of extra-care housing available across East Sussex using the following methods.</p> <ul style="list-style-type: none"> • Develop the Extra Care Scheme in Peacehaven over next two years in partnership with housing associations. • Promote extra-care housing that includes social rented and privately owned properties. • Work with private developers, planners and housing departments to develop supported housing. • Work with partners to bid for funding from the Housing Corporation to develop extra-care housing schemes. • Improve the quality and accessibility of information we provide for people who are considering moving into supported accommodation (such as sheltered housing and extra-care housing) to give them more choice and control over their future. <p>Aims: Joint working Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>
<p>12 Work with residential care homes and home-care providers by introducing:</p> <ul style="list-style-type: none"> • new contracting and service arrangements with independent care providers; • balancing value for money and long-term costs; • new technology to improve efficiency and so leave us with more money to spend on care services; and • new opportunities for health and social services to work together to purchase services from the independent providers of residential and nursing care <p>Aims: Quality Outcome: Personal dignity and respect</p>	<p>Year 1</p>

<p>13 Develop modern, needs-led residential services in partnership with primary care trusts (PCTs) to:</p> <ul style="list-style-type: none">• develop service models for providing residential services through the 'Age Well' private finance initiative(PFI) project, with particular emphasis on the needs of older people with mental-health problems Age Well will provide 4 new purpose built local care establishments across the county ; and• provide a total of 188 beds and at least 63 places for day therapy and consultations. <p>Aims: Joint working Outcome: Providing services and using resources</p>	<p>Years 1 to 2</p>
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