

# East Sussex

## Local system review report Health and Wellbeing Board

Date of review:  
13-17 November 2017

### Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we can understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

### The review team

Our review team was led by:

- Delivery Lead: Ann Ford, CQC
- Lead reviewer: Wendy Dixon, CQC

The team included:

- Two CQC reviewers
- One CQC strategy lead
- One CQC analyst
- One CQC Expert by Experience
- Four specialist advisors (three former local government Directors of Social Services and one Nurse Clinical Governance Lead).

## How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on **older people aged over 65**.

We also focused on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

- Maintaining the wellbeing of a person in usual place of residence
- Crisis management
- Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area, we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use services, their families and carers. The people we spoke with included:

- System leaders from East Sussex County Council (the local authority), the East Sussex

Better Together (ESBT) and Connecting 4 You (C4Y) programme leads

- East Sussex Healthcare NHS Trust (ESHT), Brighton and Sussex University Hospitals NHS Trust (B&SUH), Sussex Community NHS FT(SCFT), South East Coast Ambulance Service NHS Foundation Trust (SECAMB)
- Health and social care staff, including social workers, GPs, discharge planning coordinators housing officers and reablement staff
- Members of the local voluntary sector including healthwatch, and community, social enterprise sector (VCSE) representatives, plus provider representatives
- People using services, their families and carers who attended a local dementia involvement group and a carers support group

We reviewed 16 care and treatment records and visited 15 services in the local area including an acute hospital, intermediate care facilities, care homes, GP practices, urgent care and hospice services.

## The East Sussex Context

### Demographics

- 23% of the population is aged 65 and over.
- 94% of the population identifies as white.
- East Sussex is in the 20-40% least deprived local authorities in England.

### Adult Social Care

- 249 active residential care homes:
  - One rated outstanding
  - 171 rated good
  - 63 rated requires improvement
  - Two rated inadequate
  - 12 currently unrated
- 79 active nursing care homes:
  - One rated outstanding
  - 45 rated good
  - 21 rated requires improvement
  - Three rated inadequate
  - Nine currently unrated
- 98 active domiciliary care agencies:
  - 54 rated good
  - 14 rated requires improvement
  - 30 currently unrated

### GP Practices

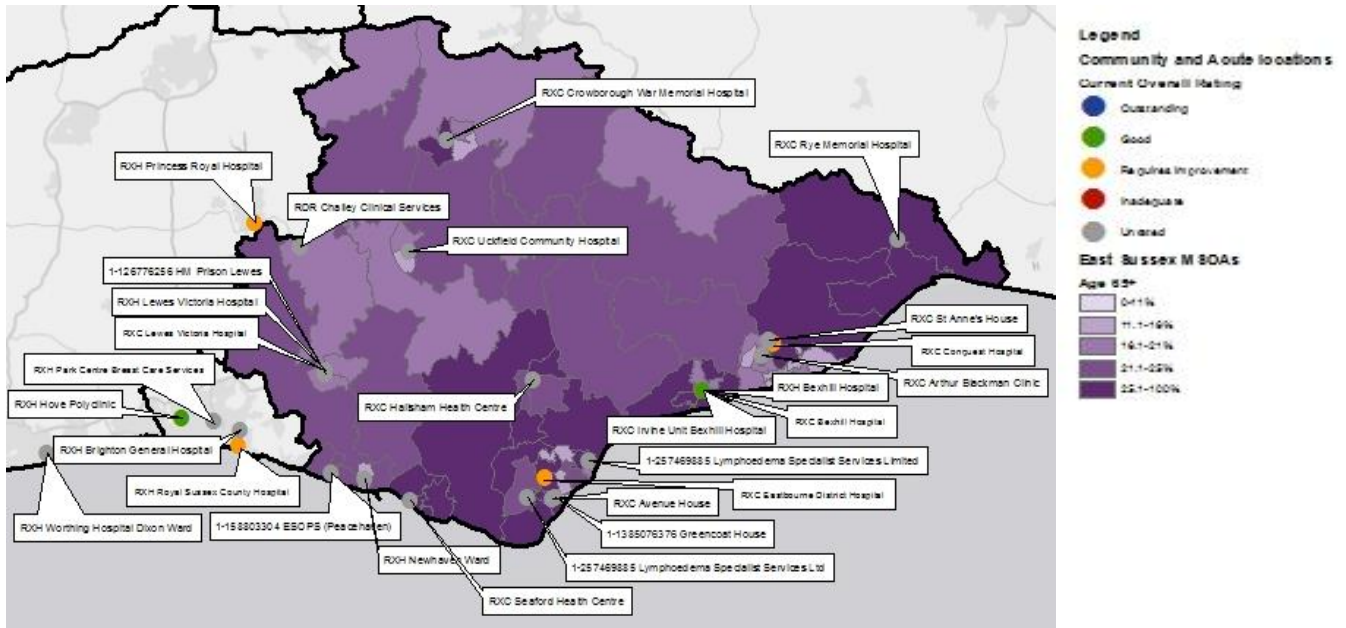
- 64 active locations
  - Three rated outstanding
  - 54 rated good
  - Two rated requires improvement
  - Two rated inadequate
  - Three currently unrated

### Acute and community Healthcare

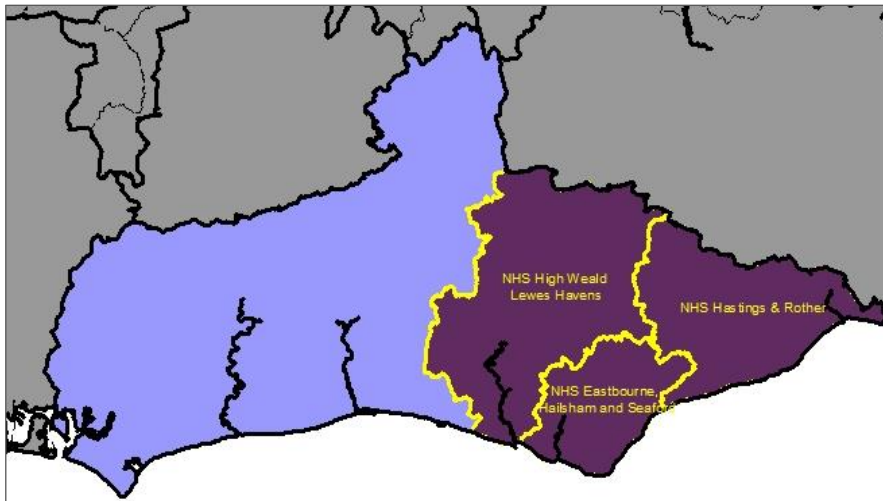
Hospital admissions (elective and non-elective) of people of all ages living in East Sussex were almost entirely to:

- East Sussex Healthcare NHS Trust
  - Received 66% of admissions of people living in East Sussex
  - Admissions from East Sussex made up 98% of the trust's total admission activity
  - Rated requires improvement overall.
  - The trust is also the main provider of community services within the area.
- Brighton and Sussex University Hospitals NHS Trust
  - Received 22% of admissions of people living in East Sussex
  - Admissions from East Sussex made up 24% of the trust's total admission activity
  - Rated inadequate overall.

*All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.*



Map 1: Population of East Sussex shaded by proportion aged 65+. Also, location and current rating of acute and community NHS healthcare organisations serving East Sussex.



Map 2: Location of East Sussex LA within STP. Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Havens CCG are also highlighted.

## Summary of findings

### Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- East Sussex was within the Sussex and East Surrey Sustainability and Transformation Partnership (STP). The STP had not begun to function effectively across East Sussex due to a lack of investment and infrastructure, and system leaders anticipated that the recent appointment of an independent Chair would accelerate STP plans. At the time of our review there were three 'places' within the STP – Coastal Care, Central Sussex and East Surrey Alliance (which includes C4Y) and ESBT. Each area had a place based plan for integrated health and care to manage population health, invest in primary care and prevention and reduce hospital activity. to developing strategies to supported integrated working through the STP.
- In East Sussex, three Clinical Commissioning Groups (CCGs) formed part of two (of three) place based plans of the STP. System leaders acknowledged that while the STP had the right membership, it had not had effective oversight of all services within the East Sussex footprint. System leaders felt that the STP had previously been too passive as a body and as the STP was comprised of 24 organisations it was sometimes unwieldy as a decision-making forum. System leaders acknowledged that with the introduction of a new chair for the STP there was an opportunity to improve the effectiveness of the STP.
- There were two separate transformation strategies across East Sussex, East Sussex Better Together (ESBT) and Connecting 4 You (C4Y). Though they had separate visions there were commonalities across both strategies, with a focus on prevention and supporting people to age well.
- System leaders in East Sussex had a clear and aligned purpose and vision for providing health and social care services, articulated through the two different strategies that spanned the local authority area. ESBT served the population of Eastbourne, Hailsham, Seaford, Hastings and Rother and C4Y served the population of High Weald, Lewes and Havens.
- There was political will and acceptance that a shared vision was required by the leaders across the system to work together to improve and ensure the sustainability of services during a period of change in East Sussex. At the time of our review there had been many recent changes to the senior leadership across the system, including the Chair of the STP and one of the CCG Chief Officers.

- Through interviews with system leaders it was clear there was a strong commitment and high level of trust between the system leaders, however feedback from interviews with frontline staff and our relational audit indicated that joint working was hindered by significant financial pressures in several organisations within the system and people's experiences of a blame culture.

#### **Is there a clear framework for interagency collaboration?**

- There was evidence of analysis of need to support resource allocation and the setting of priorities within East Sussex County Council (ESCC), ESBT and C4Y. Partners were aware of what the financial pressures within the system were and were committed to delivering services for older people based on quality outcomes within budget. However, financial pressures were cited in the relational audit as a barrier to fully integrated working.
- The older people's information displayed on the website of the joint strategic needs assessment (JSNA) was not fit for purpose. It was produced in February 2007 as a health assessment and since the implementation of the JSNA had not been refreshed as a joint overall document or been reviewed since. The data that covered conditions associated with old age had been updated but was not found under the older people's section of the JSNA and was accessed by searching for a condition. There was not an overarching narrative that described the current needs of older people in East Sussex and the system's future recommissioning of services.
- The dementia section of the JSNA was completed in November 2016. This was an extensive document that identified best practice, service provision, financial costs and interventions that could improve managing dementia at CCG level. It included a comprehensive gap analysis and clear recommendations for commissioners and providers.
- Preventative approaches to health and social care delivery were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain in their own home and maintain their wellbeing. East Sussex had lower rates of attendance of older people at A&E than comparator areas and nationally. However, financial pressures within the system meant that spending on preventative services was to be reduced in the next financial year.
- There were some good examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs.
- The daily calls and weekly MDT meetings set up to manage delayed transfers of care

(DToC) across the system were valued by staff and had a positive impact on the number of people being discharged to their own homes or into reablement and intermediate care services. DToC figures to July 2017 suggested some improvement, although East Sussex was still above comparator and England averages. Recently submitted data from the local system indicated that there had been further improvement. Our analysis of more recent DToC figures showed DToC performance was improving in East Sussex to be more in line with comparator areas, although still above the national average.

- The system was confident that further implementation of the high impact change model would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.
- The East Sussex Health and Wellbeing Board (HWB) was made up of senior officers with high levels of support. The East Sussex HWB did not have a direct role in managing performance and overseeing improvement. A number of governance functions had been delegated to the ESBT Alliance Governing Board; ESBT Strategic Commissioning Board and Connecting 4 You Programme Board. However, as a forum to challenge and to support the system's joint strategic approach, the HWB lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more closely.
- Nursing home and domiciliary care agency (DCA) capacity issues were being addressed through multi-agency working. The Supplier Relationship Programme was addressing DCA provision and the Care Home Plus programme was addressing nursing home provision. These respective programmes had been implemented relatively recently (2017) and had some impact in improving capacity issues across the system. From March to June the shortfall in capacity fell in DCA from 908 hours to 304 hours. The Care Home Plus programme had procured a number of block contracted beds at enhanced rates within residential care homes for clients with no nursing requirement but with significant mobility issues, who would otherwise go to a nursing home due to their high levels of need. This then freed up nursing home beds, increasing capacity.

#### **How are interagency processes delivered?**

- There were shared performance metrics between ESCC, ESBT and C4Y which were scrutinised at the Executive Board. However, these were not aligned with all system partners, for example the acute trusts were measured by different indicators to ESCC services to meet the requirements of different national regulators.

#### **What are the experiences of front line staff?**

- Health and social care professionals in East Sussex were dedicated to supporting people



using services, their families and carers. Staff that we spoke with felt that the leaders of their services were visible, responsive and inclusive. Frontline health and social care staff reported that staff generally communicated well across agencies. However, some staff reported in the relational audit that there was still a lack of understanding about roles and responsibilities, particularly around assessment processes, which led to people saying they felt a blame culture still existed.

- Overall there was a collaborative multi-agency approach that was well established because of new initiatives that supported joint working and the building of relationships. The Joint Community Rehabilitation (JCR), Occupational Therapy (OT) and services provided from Milton Grange were good examples of these.
- In the main, feedback from front line staff was positive, although in interviews, focus groups and the relational audit they identified issues about workforce; particularly about the recruitment and retention of GPs and nurses in nursing homes. There were system-wide plans in place to mitigate risks associated with these issues. New models of care, which would promote integrated working and best use of resources, were being considered.

#### **What are the experiences of people receiving services?**

- There was a wide range of services available to people in East Sussex to help prevent them from being admitted into the hospital. The Voluntary, Community and Social Enterprise (VCSE) sector provided services that were diverse and valued by people. Concerns were expressed in respect of access to intermediate care, nursing home placements and packages of care once a person no longer required services from an acute hospital. Most people using services and their families told us they felt included in decision making about their care, treatment and support. However, some families and carers did not feel fully involved in arranging their family member's discharge and associated support services.
- We found a multidisciplinary, integrated approach to delivering a range of key services including the Health and Social Care Connect service, which provided a single point of contact for people wanting information and access to services in East Sussex. The service provided a proactive and solution-focused service that improved people's experiences when they needed to access services.
- There was effective involvement of people using services, their families and carers in the development and improvement of health and social care services. People living with dementia were identified early and they, their families and carers were well supported. There was a range of community support groups that provided advice, support and guidance to people using services and their families.

- Our analysis of ASCOF data (2016/17) showed that levels of overall satisfaction with ASC care and support for people aged 65 and over in East Sussex (67%) were above the national average (62%) and comparator area average (65%).

## Are services in East Sussex well led?

### Is there a shared clear vision and credible strategy which is understood across the health and social care interface to deliver high quality care and support?

*As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, interagency and multidisciplinary working and the involvement of people who use services, their families and carers.*

*While the STP had not yet begun to function effectively we found evidence that the leaders across the system were committed to working together and further developing strategies for working collaboratively with the STP. There was evidence that people who use services, their families and carers were engaged by partners in developing and improving health and social care services.*

#### **Strategy, vision and partnership working**

- There were two separate transformation strategies across East Sussex, ESBT and C4Y, representing different commissioning areas. Though they had separate visions and strategies there were commonalities across both, focusing on prevention and ageing well. The Sussex and East Surrey Sustainability and Transformation Partnership was responsible for the planning and provision of health and care services across East Sussex and its larger system. System leaders acknowledged that while the STP had the right membership, it had not had effective oversight of all services within the East Sussex footprint. System leaders felt that the STP had been too passive as a body and as the STP was comprised of 24 organisations it was sometimes unwieldy as a decision-making forum.
- At the time of our review, a new Chair of the STP had been appointed and was to take up post in January 2018. It was acknowledged that there was an opportunity to renew and refresh governance arrangements to give greater oversight of health and social care services and deliver better integrated services.
- The two overarching transformation strategies and associated transformation programmes, ESBT (covering the Eastbourne, Hailsham & Seaford and Hastings & Rother CCG areas),

and C4Y (covering the High Weald Lewes Havens (HWLH) CCG area), were at different stages of maturity at the time of our visit, however they shared a common vision for people living in East Sussex.

- We accessed a public health assessment for older people that was on the JSNA website that had not been updated since February 2007. Due to the length of time since the section was produced the information contained was not fit for purpose and could not be used as a document to inform commissioning.
- From our online relational audit tool, we received 122 responses from people working at various levels across the health, social care and voluntary sectors in East Sussex. Although the responses were not from a representative sample they indicated that people working in health and social care services worked towards a shared vision and purpose.
- The ESBT transformation programme and strategy was better embedded and understood by staff working in these areas in comparison to C4Y. ESBT was established in August 2014 and had completed a 150-week programme of work to implement the transformation and integration of local health and social care system. C4Y had been introduced more recently, in March 2016, and was still in the process of implementing its transformational programme.
- Through ESBT, East Sussex was operating a shadow form of Accountable Care commissioner-provider alliance across health and social care, supported by a Memorandum of Understanding agreement /partnership contract. This alliance of commissioner and provider organisations commenced in April 2017. The Alliance will decide the most appropriate organisational arrangements for the Accountable Care System in East Sussex. However, C4Y was not as well developed with regard to the development of an ACS.
- Through interviews with system leaders it was clear there was a strong commitment and high level of trust between the system leaders, however feedback from interviews with frontline staff and our relational audit indicated that joint working was hindered by significant financial pressures in several organisations within the system and people's experiences of a blame culture.
- All system leaders told us of the shared challenge to reduce delayed transfers of care and we were informed of recently developed operational protocols that had improved flow. Data showed the whole system had made improvements to reduce the number of DTocCs in the system over recent months. While the system had not yet met the targets set out in the BCF, more recent data showed further improvement. Although we were presented with

strategies and objectives that outlined the plans for more long-term and sustainable services (the Interim Accommodation and Bedded Care Strategy) these had not developed into actions at the time of the review.

### **Involvement of service users, families and carers in the development of strategy and services**

- System leaders said they were committed to involving people who use services, their families and carers in the development of ESBT and C4Y strategies. Through both transformation programmes, East Sussex had a history of engagement with people who use services, families, carers and organisations that represented them.
- People who use services, their families and carers were involved in the design of the recently formed health and wellbeing stakeholder group through local engagement events. This group was made up of representatives from health, social care, local communities, partner agencies, and organisations representing people who use services, their families and carers. The group played an active role to influence and participate in service design and delivery.
- In developing the health and wellbeing stakeholder group an engagement event was held with representatives from health, social care, the voluntary sector, local communities, housing, Police, Fire Service, organisations representing people who use services, their families and carers, and Healthwatch to gain feedback on what worked well, how co-production and co-design could be improved and what they felt were the priorities for working collaboratively in the future. The feedback from this event had been incorporated into the terms of reference for the group which would report to the ESBT Strategic Commissioning Board and C4Y Programme Board and as a result influence developments across the system.
- People living in East Sussex were encouraged to take an active role in influencing service design and delivery through groups such as the East Sussex Senior Association (ESSA), 'Care for the Carers Strategy Group' and the public reference forum. Targeted engagement events were held during 'Dementia Awareness Week' and 'Carers Week' to gain the views of people who use services, their families and carers.
- People who use services, their families and carers were well represented by the local Healthwatch group. Healthwatch East Sussex were represented on a range of executive committees that spanned all dimensions of health and social care, including dementia, discharge planning and quality in care homes. They were also represented on the ESBT and C4Y co-commissioning joint committees.

### **Promoting a culture of interagency and multidisciplinary working**

- There was an emerging culture of interagency and cross-boundary working across East Sussex. The Health and Social Care Connect (HSCC), the joint Community Rehabilitation team and Occupational Therapy services demonstrated joint and partnership working. These services had both health and social care professionals working together using shared records and management structures. However, there was an opportunity to develop this model further with regard to the falls service in particular within the C4Y area.
- There was no universal IT system used across services operating in East Sussex. Technological barriers were cited as causing some of the delays to assessments, especially in urgent care centres, where staff were unable to access information from GPs despite using the same system. This meant that GPs in the urgent care centre were having to make decisions about a person's care and treatment without information that was held by the system.

### **Learning and improvement across the system**

- Learning took place at an organisational, but not always at a system-wide level. Following a significant number of inappropriate referrals to one of the UCC, a GP was introduced to review calls to identify the themes. While this had given them insight to the service, this learning had been shared but not acted upon by the 111 service which meant that inappropriate referrals were still being received.
- There were missed opportunities to ensure there was system-wide learning and improvement. The system could benefit from ensuring there are opportunities to come together and discuss challenges, evaluate the effectiveness of initiatives and generate shared solutions.
- Quality and performance were monitored and discussed in a variety of forums. At the time of our review there were multiple pilots being undertaken, including the discharge to assess pathway and the trusted assessor model. Learning from these pilots was shared with system leaders to demonstrate the impact they were having and inform system-wide roll out, however the learning was not always cascaded to reach wider system partners or frontline staff. Mechanisms for shared feedback and learning were recognised by the system as one of the main areas for development as the system moved towards providing more integrated services.
- Across the system, newsletters and email communications were used to share learning and feedback with staff, however this was only at an organisational level. There was not a system-wide mechanism for cascading messages to incorporate all partners and foster a view of one system for East Sussex.

- Social care providers reported that they had very limited opportunities to feedback to the system and develop services for people. The 'inter care group' was set up to meet every six weeks to oversee this work, however the group had not always met consistently.

### **What impact is governance of the health and social care interface having on quality of care across the system?**

*We looked at the governance arrangements within the system, focusing on collaborative governance, information governance and effective risk sharing.*

*Each organisation in the system had separate governance arrangements. Governance structures were aligned across the two transformations programmes, ESBT and C4Y. With regard to the STP there was an opportunity to renew and refresh governance arrangements. The Health and Wellbeing Board provided strategic oversight of commissioning decisions across health, social care and public health, including the two transformation programmes. It also monitored delivery and performance and provided support to the system's joint strategic approach. However, it did not effectively challenge progress and performance of the local system's transformation agenda.*

#### **Overarching governance arrangements**

- It was acknowledged by system leaders that there was an opportunity to renew and refresh governance arrangements to give greater oversight and to be able to deliver better integrated services for people living across the whole of East Sussex.
- Governance structures were built around the two transformation programmes, supported by the respective organisations' individual internal governance structures. The A&E Delivery Boards, Health and Wellbeing Board, and the governance arrangements as set out in the Better Care Fund (BCF) plan, confirm separate governance arrangements for both ESBT and C4Y strategies.
- In ESBT an alliance agreement was in place together with an integrated five-year whole system strategic investment plan which described the Year of Care costs over five years and the shifts between care settings. An integrated governance structure was in place to support commissioning and delivery, including strategic commissioning and oversight, and executive leadership of the whole system.
- The alliance aimed to provide increased flexibility in the way resources were used in the

system to test new ways of working and improve services for the local population, as well as paving the way for future models that integrated the whole system in the ESBT area.

- The ESBT strategy was monitored through a number of partnership boards including the ESBT Scrutiny Board that scrutinised performance from the perspective of the County Council. It provided oversight of ESCC's involvement with the programme, scrutinised impact on ESCC services and made recommendations to ESCC cabinet.
- The ESBT Alliance Executive was an integrated senior management team with responsibility for the delivery of agreed strategic investment plans (SIPs), proposals for service developments and budget changes needing executive authorisation. It was also responsible for managing operational delivery of all specified health and care services and the escalation of identified risks to the ESBT Alliance Governing Board.
- The ESBT Alliance Governing Board had responsibility for developing and agreeing delivery of the SIP and the operation of the ESBT Alliance Agreement, holding the ESBT Alliance Executive to account for delivery of agreed plans, management of risk and any changes to proposed service arrangements, performance and resource allocations. The board also led the development of proposals for the full ESBT Alliance accountable care model. It reported to the Strategic Commissioning Board (SCB) which is made up of East Sussex County Council, Eastbourne, Hailsham and Seaford CCG, and Hastings and Rother CCG, and also to the boards of East Sussex Healthcare NHS Trust and Sussex Partnership NHS Foundation Trust.
- The C4Y transformation strategy covered local health and social care services and aimed to meet the needs of the HWLH population. C4Y was a partnership between HWLH CCG, ESCC, Sussex Community Foundation Trust (SCFT) and Sussex Partnership Foundation Trust (SPFT).
- The C4Y programme was developing a new community model of care for HWLH at the time of our review and was adopting the multispecialty community provider (MCP) model. This was to develop a model to deliver accountable care across the sub-region.
- The operational delivery group, MCP group and the finance and strategy group reported to the C4Y Programme Board. The Board's function was to monitor performance and delivery and report to the HWLH CCG governing board informing the cabinet and the Health and Wellbeing Board.
- The HWB covered the whole of East Sussex and its members included representation from

the ESBT and C4Y transformation programmes and local Healthwatch. District and borough council representatives and health and social care providers were not regular members of the board and only attended by invite.

- The HWB provided strategic oversight of commissioning decisions across health, social care and public health. The HWB was responsible for monitoring delivery and performance and provided support to the system's joint strategic approach. Following a review of minutes from meetings and speaking to system leaders however, it was felt that as a forum to challenge, the HWB lacked rigour and required improvement to challenge the local system's transformation agenda and monitor progress more robustly.
- System leaders from across the ESBT and C4Y, together with leaders in the county council and the acute trust, report to the HWB. This enables the board to have oversight of progress of the transformation programmes although these are developed separately for ESBT and C4Y. These systems had different objectives and some members crossed area boundaries which meant that there might not always be consistent membership at board and governance meetings.

#### **Information governance arrangements across the system**

- The East Sussex information governance plan included the Sussex and East Surrey Local Digital Roadmap (produced in January 2017) and described how STP priorities would be supported. The timescales for the delivery of integrated information technology was due for completion in 2020. At the time of our review the work was at an early scoping stage.
- A newly appointed chief nurse was in place to work across both ESBT and C4Y footprints. This was a strategic role which encompassed streamlining information governance, quality improvement and learning across the system. This work was at a very early stage at the time of our review. There was recognition that the two systems worked differently and that aligning information governance across East Sussex was a challenge.
- At the time of our review, a business case for an Integrated Digital Care Record (IDCR) had been submitted for approval. Work on the ESBT digital programme had started in April 2016 and was signed off in June 2016 and refreshed in the summer of 2017. ESBT had installed integrated systems including a data warehouse which enabled ESHT Acute Care, GPs and adult social care to view a shared portal with information regarding admissions, discharge and transfer, pathology and patient demographic data.
- Frontline staff felt that information technology and information sharing was a significant challenge. For people who accessed primary care out of hours there was a reliance on sharing information with GPs by courier or by fax. This meant that there was a risk of



delays or information not being received in the right place at the right time. Frontline staff told us that an overarching care summary, described in the Digital Roadmap as the Shared Health and Care Record, only provided high level information such as whether a person had a health condition and did not provide more detailed information which would ensure that patients received appropriate and timely care and treatment. However, the Local Digital Roadmap described this as a record that would develop by 2020 and would enable people who received services to be able to input information through a patient portal meaning information was up to date and accurate.

- Some practical steps had been taken to support operational staff to share information on NHS and East Sussex County Council sites. This would enable staff who were co-located to access their systems to share information with colleagues.

### **To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?**

*We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.*

*Developing the capacity and capability of the health and care workforce was recognised as a key priority for East Sussex and was identified as a priority area in the BCF plan. There were plans in place to ensure the system had a suitably skilled workforce that could meet the needs of the local population.*

#### **Developing a skilled and sustainable workforce**

- The workforce group was a well-established group that included representatives across the wider system in East Sussex to develop the local workforce, however the independent sector was not included in the group. One of the key priorities of the group was organisational development. An organisational development diagnostic had been completed to identify gaps and risks to workforce procurement and supply. Subsequent workforce strategies were based on findings from the diagnostic exercise.
- It was recognised that for services to be able to integrate and staff to work closer together, the right infrastructure needed to be provided. The ESBT communications team had produced videos and issued newsletters for staff and the public to inform them of changes that would enable better joined up working.
- The ESBT and C4Y workforce strategies were at different stages of development. The ESBT region had published a workforce strategy in 2016 and had reviewed it in early 2017 to ensure it was fit for purpose.

- The C4Y workforce strategy was still in development at the time of our review and did not have a specific workforce lead. The ESCC adult social care workforce development lead was responsible for ensuring that any workforce developments in the ESBT area were spread across the whole county footprint. Workforce strategy leads for C4Y were fully engaged in this approach.
- Workforce development teams felt that they had support from senior leaders in the system. Strong links across stakeholders to develop plans meant that the workforce groups could collaborate effectively in the design of the workforce.
- The workforce group were involved in a number of joint projects to support and strengthen the workforce across East Sussex, including offering well-established ESCC adult social care training to the independent sector as well as council staff.
- Increasing the provision of skilled and trained personal assistants was a long standing priority in East Sussex. The Support With Confidence scheme was established to support personalised service provision and to attract additional people into a diversified health and social care workforce. The workforce group had also been involved in a number of initiatives in the ESBT area to address the shortage of GPs, including a GP fellowship scheme to attract and retain GPs and a bid to recruit international GPs as part of a national scheme. This was a joint initiative with the STP to avoid competition with other areas. Work was also underway to embed the physician associate role in primary care – there were already approximately 300 in place and work was ongoing to attract more to the role. An implementation group was established to discuss and agree workforce initiatives.
- Our analysis of data spanning July 2016 to June 2017 suggested that acute hospitals that served people in East Sussex had better retention of staff than other trusts. At Brighton and Sussex University Hospital staff turnover was significantly lower across all staff groups when compared to the England average. At East Sussex Healthcare NHS Trust staff turnover was lower than the England average in all staff groups, apart from the medical and dental staff group which was higher at 11% compared to an England average of 8%
- Turnover of staff within ASC had increased from 2013/14 to 2015/16 from 23% to 30.8%. Levels of staff vacancies remained consistently lower than the England average for the same period. However, the rate of vacancies had increased and was slightly above the comparator average by 2015/16 at 6.2% compared to 6.0%.

**Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?**

*We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.*

*The older person's section linked to the JSNA website had not been updated since 2007 and there was no overarching narrative which could be used to inform the commissioning of services across East Sussex. It was acknowledged that the availability of domiciliary care packages and nursing home placements were an issue with regard to providing timely support to people being discharged from hospital. Some short term tactical responses to market shaping and increasing capacity across East Sussex had been put in place including an increase in fees and an enhanced care home programme. Commissioners across health and social care had individual systems in place to monitor and respond to performance issues. However, there was evidence of partnership working to drive improvements. At the time of our review a new market support team was being planned to support providers to improve CQC ratings and the sustainability of services.*

**Strategic approach to commissioning**

- The older people's section on the JSNA website was written in 2007 and was not fit for purpose, there was not an overarching narrative that described the needs of older people in East Sussex that could be used to influence or direct a commissioning strategy. The JSNA for dementia was more recent and comprehensive, completed in November 2016.
- The JSNA for dementia identified that diagnosis rates had increased in each CCG since national targets were introduced but identified that rates could be further increased. A good gap analysis was in place and the section made clear recommendations for commissioners and providers.

**Market shaping**

- We found that there were some short term tactical responses to market shaping and increasing capacity across East Sussex as well as some more responsive interim responses being implemented to secure and sustain a viable workforce.
- The local authority and its partners had completed a draft accommodation and bed based care strategy in September 2017. This was yet to be agreed through the system's governance processes. One of the initiatives outlined in the strategy was to engage with the nursing care market to deliver a specialist service providing 100 nursing places that would provide services at an ESCC fee rate. Some work had begun to develop initiatives

set out in the strategy but new initiatives would not be in place to support winter pressures in the current year, e.g. the plan to further develop extra care housing was not due to start until the end of 2017.

- Our analysis showed that the provision of adult social care beds, both nursing and residential, was higher per population in East Sussex compared to comparator local authority areas and the England average. Both these numbers had slightly decreased, by 1% between April 2015 and April 2017 for nursing home beds and less than 1% for residential beds in the same period. There were fewer domiciliary care agency locations per population based in East Sussex compared to comparator areas and the national average.

To support patient flow, 24 block contracted nursing home beds had been purchased by ESBT and C4Y to be used as interim placements for hospital discharge. This enabled longer-term care requirements to be arranged while reducing discharge delays from hospital. The beds were funded at an enhanced rate and this had resulted in the market releasing this capacity from stock usually reserved for self-funding clients.

- It was acknowledged that the availability of domiciliary care packages was an issue with regard to providing timely support to people being discharged from hospital. To help with addressing this, ESCC had increased payments to agencies to support with the recruitment and retention of staff. Recent information provided by the system showed there had been a significant reduction in the shortfall of domiciliary care hours available to people in East Sussex.

### **Commissioning the right support services to improve the interface between health and social care**

- East Sussex had a long history of joint commissioning arrangements, dating back to 2012 when a Joint Commissioning Board was established to oversee all joint commissioning activity across health and social care services, including pooled budgets and other joint commissioning arrangements (e.g. integrated community equipment services; continuing healthcare; mental health crisis response services).
- The shortages of suitable nursing home beds and domiciliary care packages were recognised as significant factors for delays in people being discharged from hospital care across the system, and a barrier to a seamless interface between health and social care services. To address these issues a Supplier Relationship Programme to support domiciliary care, and the Care Home Plus programme to support the nursing home sector, had been launched in 2017. Recent local data supplied by the system indicated performance was improving with reductions in delays due to awaiting nursing home and domiciliary care packages.

- The Supplier Relationship Programme had been established to help improve working relationships and build a better understanding of the factors contributing to capacity issues in the sector and to adopt a collaborative approach to resolving issues. There had been an increase to DCA fees of up to 17% in April 2017 and from March to June the shortfall in capacity fell from 908 hours to 304 hours. However, the commissioning approach to day care was fragmented and rates differed across East Sussex and the services were operating under capacity. The commissioning approach to buildings-based day care was being reviewed, in light of a significant fall in demand for such services as people were taking the opportunity to access more personalised support.
- The Care Home Plus programme had been launched to procure a number of block contracted beds at enhanced rates within residential establishments for clients with no nursing requirement but with significant mobility issues, who would otherwise go to a nursing home due to their high levels of need. The additional funding enabled higher staffing levels to be provided in residential homes to meet the additional need.
- Alternatives to bed based care were in the process of being developed. These focused on enhancing the offer that supported people in their own homes including the use of Disabled Facilities Grants, Integrated Community Equipment Services, Technology Enabled Care Services and increased community and primary health care services.

### **Contract oversight**

- While historically there had been issues with the quality of nursing home and DCA services in East Sussex, our analysis suggested improvements were being made, with 52% of adult social care locations found to have improved following a CQC re-inspection compared to 38% in comparator areas and nationally. However, a higher percentage of adult social care locations in East Sussex were still rated as inadequate and requires improvement by CQC compared to comparator areas and the England average.
- Commissioners across health and social care had individual systems in place to monitor and respond to performance issues and there was evidence of partnership working to drive improvements. ESBT, C4Y and the local authority had developed a joint quality team to support providers and fed into joint quality meetings attended by key partners, including Healthwatch and CQC.
- At the time of our review a new market support team was being planned to support providers to improve CQC ratings and the sustainability of services, to ensure the independent market was robust and providing high quality services.

- The ASC team from ESCC met regularly with CCG colleagues from ESBT and C4Y to discuss the market, streamline work with services, and ensure each body was offering appropriate support. ESBT and C4Y CCG representatives attended the ESCC ASC suspension panel which met weekly to discuss suspended services and actions taken, and to evaluate risk and the rate of any improvement.

### **How do system partners assure themselves that resources are being used to achieve sustainable high-quality care and promoting people's independence?**

*We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promote people's independence.*

*System leaders expressed concerns about the financial situation across health and social care. There was a shared view of the challenges and priorities across the system. System partners worked together to manage demand and govern resources. System leaders acknowledged that the delivery of a sustainable financial position, while managing the needs of a growing ageing population, was a significant challenge. Saving proposals had recently been discussed within the system and it had been determined these would be centred around the preventative agenda. In the relational audit carried out as part of the review, financial pressures were one of the barriers identified to full partnership working.*

- System leaders had a shared view on the challenges and priorities for using resources to achieve high quality sustainable care and promote people's independence. Key strategies focused on prevention and support to stay well at home, availability of care home beds (particularly nursing home beds and homecare packages), as well as provision of good quality dementia care and support in the community.
- The BCF had encouraged joint working between the system partners to manage demand and govern resources. Partners who were not signatories to the BCF had been engaged in the process, particularly the District Councils. There was still a concern that capacity would not match demand for people with dementia. Many of the market stabilising/shaping plans were in their infancy, and their success could not be measured at the time of the review.
- Budgets for 2016/17 were pooled in line with the transformation programmes: ESCC, Hastings and Rother and Eastbourne Hailsham Seaford Clinical Commissioning Groups, (ESBT) and High Weald Lewes Havens Clinical Commissioning Group (C4Y). For both pooled budgets, ESCC acted as the host authority, with responsibility for the day-to-day governance and accountancy for the pooled resources.
- £8.074million of the Improved Better Care Fund (iBCF) additional grant was being invested

along with ASC core budgets to ensure that there was funding in social care for the placements required. £3.239 million was being made available to support clinical pathway and service investments to ensure the system's sustainability. Our analysis showed the number of people deemed eligible for standard NHS CHC per 50,000 adults in each of the three CCGs in East Sussex on the last day in Q1 2017/18 was below the level across the England. The rate eligible for fast track CHC (usually used for end of life care) was also lower in each of the three East Sussex CCGs than across England. System leaders acknowledged that the uptake of continuing healthcare funding would continue to present a risk.

## Do services work together to keep people well and maintain them in their usual place of residence?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence**

### **Are services in East Sussex safe?**

*There was a system-wide commitment to keeping people safe in their usual place of residence and proactive prevention and intervention were key priorities in both ESBT and C4Y programmes across East Sussex.*

*Safeguarding processes were well established. Frontline staff received training and told us they were supported to address any safeguarding issues*

- The Health and Social Care Connect (HSCC) service was developed by the system to support people to move safely across the health and social care system in East Sussex. This was in response to the people of East Sussex wanting better access to services. The service was commissioned in 2014 by ESBT with the vision of a totally integrated first point of contact for people needing health and social care services in East Sussex.
- The HSCC could be accessed by health and social care professionals who could then refer people to HSCC to access health, social care and community services. People who use services, families and carers could contact the service directly for support if needed. HSCC staff could make immediate assessments and referrals and access a number of services directly, for example, safeguarding, meals on wheels, life line (support technology), or arrange a carers assessment.
- The service could also refer people onto teams within the system, for example OT clinics, rehabilitation services, frailty and the crisis response team. However, the crisis response

team could only be accessed in the ESBT area of East Sussex as services were delivered differently in the HWLH area.

- As part of planning for winter the system had begun work to avoid admissions to hospital from care homes and keep people safe at home. The initiatives that had been started included GPs posting adverts in their practices to remind patients about the need to have enough medicines for over the Christmas period, promoting the flu vaccination programme and publishing lists of alternatives to attending A&E, such as visiting their local pharmacist.
- The VCSE sector in East Sussex was involved with the winter warmth project which supported people with advice, information and practical help in periods of cold weather.
- Multidisciplinary teams (MDT) were completing ward rounds in nursing homes to identify and treat issues early, preventing people from attending A&E. This had also helped to develop stronger relationships with the independent sector.
- Our analysis showed that over the three-year period from 2014/15 to 2016/17 the rate of A&E attendances of older people in East Sussex was consistently below the national and comparator averages. Emergency admissions for older people were also consistently below the national average over the same period; in East Sussex, there were 2,581 emergency admissions of people aged 65+ per 100,000 between January and March 2017, compared to 2,873 across comparator areas and 3,196 across England.
- The rate of A&E attendances from care homes in East Sussex per 100,000 people aged 65 and over was also consistently below the national average between 2014/15 and 2016/17, although it was above the comparator average and had increased in the last two quarters of the 2016/17 financial year to be just below the national average (between January and March 2017 there were 973 emergency admissions of older people from care homes per 100,000 in East Sussex compared to 979 nationally).
- Systems were in place across the health and social care interface to safeguard people from avoidable harm, abuse and neglect. East Sussex's Safeguarding Adults Board was well established and was supported by its member agencies including the local authority, ESBT, C4Y, South East Coast Ambulance Service (SECAS), the local acute trusts, NHS England, the National Probation Service, Healthwatch, Care for the Carers and East Sussex Fire and Rescue.
- Safeguarding training was mandatory for staff working in walk-in centres and there were safeguarding leads at both walk-in centres in East Sussex. Staff at the centre felt that the



adults safeguarding process worked well, that they could follow up issues and access information about outcomes.

### **Are services in East Sussex effective?**

*East Sussex had embedded systems aiming to keep people well in their usual place of residence as well as having developed new projects and initiatives. However, these were not consistently available across East Sussex and people sometimes had different experiences dependent on where they lived.*

- Across the whole of East Sussex people who thought that they might need help and support were able to contact HSCC directly. This was an integrated contact centre that operated across the county that was available 8am to 8pm 7 days a week with emergency duty cover available outside these times. Staff at the centre could signpost people or health care professionals to services or arrange for an assessment. We saw from records and heard from frontline staff we spoke with that, when people were assessed, they were assessed holistically. The assessment took into consideration all of the person's needs and the needs of their carers, including emotional and social needs.
- Our analysis of data as at March 2017 showed that fewer people had extended access to GP appointments outside of core contracted hours in East Sussex when compared with comparator areas and the England average. Full provision of extended access (access to pre-bookable appointments on weekends and on weekday morning and evenings) was only available at 1.6% of the 64 GP practices in East Sussex surveyed, compared to 13.3% across comparator areas and 22.5% across England. A higher percentage of practices in East Sussex provided no extended access (21.9%) compared to comparator areas (13.9%) and England (12.3%).
- Out of hours (OOH) GP services were provided by the provider IC24 across East Sussex. OOHs GP services were accessed via the 111 service and telephone advice or a home visit service would be offered depending on clinical need.
- An assistive technology programme (telecare) was well established across East Sussex. As at September 2017 there were 5228 people using the service that included a 24-hour response service. This was an increase of nearly 2,000 people from the previous year and was linked to the falls prevention programme. Through the Better Care Fund expenditure in telecare had increased from £1,061m in 2013/14 to £2,371m in 2016/17.
- Access to falls prevention services were different across East Sussex. In ESBT falls practitioners were working within the Joint Community Rehabilitation team to deliver a programme which aimed to reduce the number of people falling and fracturing. The service

could be accessed by anyone who had had a fall, near miss, a fear of falling, significant impairment of balance or identified risk of falls. Services included falls assessments in people's homes and community clinics, access to new strength and balance group exercise classes and targeted support to care homes.

- The C4Y team had decided to withdraw support for the existing falls strategy and a new strategy and plan had been agreed and was to be implemented in 2018. As part of the new strategy a falls self-referral pathway and supporting communications package had been launched in October 2017. However, during the review GPs and other health professionals told us referral into the service was difficult and referrals were not always accepted when a person was only at risk of falling but had not yet fallen.
- The frailty pathway also worked differently in the ESBT and C4Y areas in East Sussex. In the HWLH area (C4Y), there was a consultant-led service which involved comprehensive geriatric assessments being completed. Training and advice services for GPs were also part of the service. Case conferences were led by the geriatric consultant with GPs attending. Where pharmacy teams were integrated into GP practices in HWLH a medicine review was included as part of the frailty service. In the ESBT area the Rockwood clinical frailty scale was used to identify and assess the needs of people in the community. Frailty practitioners from nursing and community backgrounds were supported by a hospital based consultant geriatrician to manage people on the pathway. The service had audited the first 81 patients who were referred into the service for the Advance Care Planning intervention. The audit showed an 81% reduction in hospital admissions and 95% reduction in hospital bed days when comparing their activity six months post intervention to six months prior to intervention from the frailty team.
- The frailty team for ESBT had started to work with the fire and rescue service, who conduct safety at home checks, to help identify people with frailty. This was to embed frailty within the 'make every contact count' training.
- On the ESBT programme, pharmacy reviews were completed for people living with moderate to severe degrees of frailty. Everyone was reviewed as part of a virtual ward round to determine the best plan for them. A proactive advance care plan for people approaching the end of their life was also widely used in appropriate cases.
- The walk-in centres could be accessed without an appointment and people could refer themselves. However, the walk-in centres were not always able to meet the needs of people with long term conditions meaning the only option was A&E.

### **Are services in East Sussex caring?**

*People experience a compassionate, high quality care across the system which leaves them feeling supported and involved in maximising their wellbeing.*

*The voluntary sector in East Sussex was well embedded and had developed and delivered services that were based on people's needs and preferences. Care and support were delivered in a caring and compassionate way that took in to account people's personal needs and preferences.*

- The voluntary and community sector was active and well engaged in East Sussex and provided a range of services designed to maintain and improve people's health, wellbeing and independence. There were well-established networks for engaging local people in the design, planning, commissioning and evaluation of services. 'Care for the Carers' was a voluntary organisation that was funded to deliver support, coaching and training to carers to support them in their role and help maintain their own wellbeing.
- Carers were also involved in a number of consultation and reference groups to ensure effective, representative and equal involvement in strategic meetings and to ensure the voices and experiences of carers were heard
- Domiciliary and care home providers felt that their staff understood people's needs well and that they could support people when they were assessed. This was evident through case tracking and dip sampling of records which demonstrated that people's needs were assessed holistically and people's individual preferences in terms of privacy and dignity were considered. There were teams based in the community to assess and support the wider determinants of health including support to prevent social isolation and promote inclusion.
- Adult Social Care Outcomes Framework (ASCOF) data showed the overall satisfaction of people aged 65 and over who use adult social care services was above the national and comparator average in the last two financial years, with 67% of older people using social care services satisfied with their care and support in East Sussex in 2016/17 compared to 65% across comparator areas and 62% nationally.

### **Are services in East Sussex responsive?**

*Services had been developed and delivered to proactively maintain people in their usual place of residence and support them when moving across the health and social care system. Our analysis showed that more people were maintained in their usual place of residence than in other similar areas across England. This included when a care home setting was a person's usual place of residence. However, the current capacity of crisis response services available in*

*some parts of East Sussex meant that people were more likely to attend A&E and be admitted to hospital at the weekend.*

- The VCSE sector in East Sussex was well established and had worked with system partners to develop a number of services to help people to stay in their own homes. These services were delivered to people living with dementia and their carers and families. These included a supper club that met monthly in Hastings at a local pub, and a choir which carers and families could also be involved with. Carers spoken to told us they were well supported and really valued these services. We were told about the carers' card where holders of the card had emergency respite arrangements already in place should they ever need it.
- There were many opportunities for carers of people who lived with dementia to reduce social isolation, including day trips and other social events. The carers' card enabled carers to receive discounts at local businesses such as cafes and holistic therapies to encourage and support the inclusion and wellbeing of both themselves and the person being cared for.
- The 'golden ticket' programme was developed to support people living with dementia when moving across services. This was a type of individualised 'passport' containing a person's personal information, medical needs, contact numbers, information regarding their dementia, and contact details for the dementia guide (a key worker with training about dementia who supports those living with dementia who are living at home).
- Secondary care services were consulted during the development of the 'golden ticket' approach but were not currently part of the process. This was a missed opportunity to support seamless care across the health and social care system.
- The 'just in case' scheme had been introduced in care homes. Boxes for residents on the end of life care pathway were provided which contained a range of anticipatory medications to alleviate symptoms and help avoid an unnecessary admission to hospital. This also provided people with reassurance that advancing symptoms could be managed effectively in a timely way.
- In the C4Y area GPs described a lack of a timely response to requests for support out of hours. This was from the community health service as they were not available to deliver some services (e.g. IV medication) to care for people in their own home if they became unwell at the weekends. We were told about an instance where a person was suffering from a urinary tract infection. Because the person could not receive the antibiotic treatment at home and there was no nursing home bed available this led to a hospital admission.

- The falls service in ESBT accepted patients at risk of falling as well as those who had fallen. In C4Y, where at the time of our review there was no falls service, falls referrals, including for those at risk of falling, were managed via JCR rather than a specialist service. We were also told that in the C4Y area the falls service would only take people on once they had fallen rather than when at risk of falls which contrasted with the falls service in ESBT that took a more preventative approach.
- Our analysis of A&E attendances of older people showed there was a comparatively low percentage of older people in East Sussex being referred to A&E by a GP who were then discharged from A&E without any follow-up (9% were discharged in East Sussex without follow-up in the last financial quarter of 2016/17 compared to 18% across comparator areas and 17% nationally), indicating that GPs were making appropriate referrals into A&E.

## Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

### Are services in East Sussex safe?

*There were systems in place to ensure that, as far as possible, people who were in crisis were protected from avoidable harm. Local performance in terms of urgent care and the number of emergency admissions to hospital were overseen by the local A&E boards. There was work in place to identify older people at risk due to frailty that was having a positive impact on older people's experiences and avoiding unnecessary admissions to hospital.*

*However, while the numbers of older people admitted to hospital as an emergency were lower than comparator averages, people often remained in hospital longer than they needed to, putting them at risk of avoidable harm and deterioration both physically and psychologically.*

*The local Safeguarding Board managed referrals and there were suitably trained and experienced frontline staff to support good practice in this important area so that issues of abuse and neglect were escalated and managed within an acute care setting.*

*People living with dementia were sometimes supported by members of staff who were not trained to meet their needs, however many of the staff we observed delivered care and treatment in a caring and compassionate way.*

- There were many 'front door' initiatives used by the ambulance service and three A&E

departments in East Sussex to treat people quickly and prevent them from being admitted to hospital. For example, following assessments paramedics could provide basic medications and speak to a medical practitioner if a prescription was required.

- NHS England's Ambulance System Indicators showed that, between August 2016 and July 2017, the proportion of 999 calls that were attended by a South East Coast Ambulance Service crew but not taken to A&E was above the national average (47% in July 2017, compared to 38% nationally). GPs were situated in A&E departments in Brighton and Eastbourne Hospitals and there were plans to start this at the Conquest Hospital in Hastings in early 2018. GPs saw patients whose conditions were assessed as less urgent and where appropriate these patients were referred to other services such as the crisis response service which provided intensive care and support in people's homes for up to 72 hours.
- When the urgent and emergency care services were under pressure there was a system-level escalation procedure to manage risks to service delivery; the Operational Pressure Escalation Levels (OPEL) framework. System partners had agreed these and were implementing the actions to be taken when levels reached level 3 and 4. Escalation processes had been reviewed and agreed and as a result, if there was no registrar available to review a patient, staff could go straight to a consultant for further advice.
- At Conquest Hospital, we observed a number of people with dementia being cared for on one ward. The ward was extremely busy with seven patients requiring one to one support. There was an inadequate number of suitable staff on duty and one of the staff providing support was a security guard. We raised our concerns at the time of the review with senior leaders so that immediate remedial action could be taken.
- The practice of security staff monitoring vulnerable older people in an acute hospital setting needs to be urgently reviewed and discontinued.

### **Are services in East Sussex effective?**

*Limited digital interoperability meant there was no single shared care record in East Sussex. System partners needed to work more collaboratively when a person was receiving urgent care and accessing crisis services. There were multiple and confusing points to navigate through the system due to the number of services working in similar ways in different geographical areas. The 'Let's get you home' policy was not being consistently implemented.*

- While services designed to improve flow through the health and social care system were evidence based, there were multiple and confusing points caused by multiple services operating in similar ways in different localities. This put people at risk of unnecessary

delays as both people and staff tried to navigate the system. Health and Social Care Connect (HSCC) mitigated this risk somewhat by providing a single point of access, with signposting into health and care services for both members of the public and professionals. However, there was an opportunity for the system to reduce the risk further by streamlining access, aligning services operating in similar ways and providing sufficient information to help people make informed decisions.

- There was a choice policy in place, which was included in the 'Let's get you home' information given to patients as part of discharge planning. This was not understood by all staff or universally applied. We heard from various sources that due to demand outweighing supply in affordable, high-quality community care, delays were not uncommon. People and their families were refusing placements and choosing to wait for their first choice of placement in hospital rather than waiting in an alternative out of hospital care setting.
- There was limited digital interoperability of records systems, which frontline staff described as a barrier to being able to share accurate, real-time information and in turn contributed to delays and unnecessary diagnostic tests. Urgent Care centres had the same information system as GPs (EMIS) however they did not have access to patient records. They were also not able to access patient information in relation to care and treatment received in an A&E setting. Improving information sharing systems would facilitate more informed decision making and potentially prevent further admissions to hospital.

### **Are services in East Sussex caring?**

*Frontline staff understood the importance of involving people who needed support and their families in decisions about their care. We observed good discharge support from Conquest Hospital in Hastings. However, we received mixed feedback from people and their families during our review about the discharge processes and were given an example of where relatives had to make their own discharge arrangements for their relative because of delays in the system.*

- Our review of case files showed care plans for people in hospital in the main were person-centred and included information about their personal preferences and important relationships. Matters of privacy, dignity and the person's own preferences were considered.
- Patients we spoke with in hospital knew the plan for their care and felt involved in making decisions that affected them. However, when we spoke with relatives they were less positive. They felt they were not kept up to date on the progress of any discharge and that communication and involvement could be improved.

- One example that we were told about concerned a person who required palliative care experiencing a delay in their discharge. Consequently, their relative had contacted the Mcmillan Trust independently for support regarding a future placement due to a lack of communication from hospital staff.
- Staff described how difficult it was to orchestrate a complex discharge plan because of the number of referrals required to secure appropriate support. Fragmented and cumbersome referral processes added to delays in discharge processes and did not provide the patient with a positive experience.

### **Are services in East Sussex responsive?**

*People living in East Sussex did not always receive the services they needed at the right time and in the right place. People living in East Sussex were more likely to wait for long periods in the A&E department and once admitted remain in hospital for too long. Delays in transfers of care were often due to the shortage of care packages and intermediate and reablement services and because some key support services were not available seven days a week.*

- Although staff described how the culture in the organisation had changed and how supportive other areas in the system were to help them achieve the national four-hour targets for people waiting in A&E, published data showed performance against the target had worsened year on year at both ESHT and B&SUH. Between 2014/15 and 2016/17 the proportion of people seen within four hours of arriving at ESHT had decreased from 93.8% to 80.2% and from 84.4% to 82.7% at B&SUH. Unverified data collected by the system as part of its on-going monitoring showed performance had improved and in October 2017 92.1% of people at ESHT and 87.3% at B&SUH were seen within four hours.
- Nevertheless, current performance meant that people often waited for long periods of time to be seen in the A&E department and care and treatment was not always delivered in a timely way.
- Although systems, processes and practices in A&E meant fewer people were being admitted to hospital compared to similar areas, those who were admitted often stayed in hospital longer. Our analysis of HES data from January to March 2017 showed that 35% of people in East Sussex aged over 65 and admitted as an emergency had a hospital stay lasting longer than seven days, compared to 32% in similar areas and the England average. Analysis conducted by the Department of Health showed that between March 2016 and February 2017 the 90<sup>th</sup> percentile length of stay (the point at which 90% of people have been discharged) for older people admitted as emergencies in East Sussex was 26 days, longer than any comparator local authorities.



- Between 2016 and 2017, bed occupancy at both ESHT and B&SHT was consistently above the optimal target of 85%. Bed occupancy at ESHT was slightly lower between April to June 2017(84%), but B&SHT remained at 90% over the same period.
- When people were ready to be discharged from hospital their needs were assessed to determine the support that they would need on discharge.
- We saw from the records we reviewed that people were sometimes offered step down support in an intermediate care unit or they could be offered support to return to their own homes with a package of reablement care from the Joint Community Rehabilitation (JCR) team. There were delays in people returning home from hospital because of awaiting packages of care from the JCR team.
- Out of Hours crisis response services differed across the two areas in East Sussex. There was a crisis response team covering the Eastbourne (ESBT) area of county which worked to keep people out of hospital in a time of crisis referring them to a community bed or delivering treatment for up to 72 hours in their own home. In the HWLH area (C4Y) there were similar services such as the Joint Community Rehab team but they were not able to provide the same level of care at weekends. In addition, community hospitals in that area did not admit people at the weekend because of a lack of capacity within the GP OOH service, therefore people would have to be admitted to an acute hospital.

## Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

### Are services in East Sussex safe?

*Although there were pressures on services to accept admissions of people who were leaving hospital, this was managed with a focus on ensuring that people were as far as possible protected from avoidable harm. People who lived in East Sussex were less likely than people living in other similar areas to be readmitted to hospital as an emergency within 30 days of their discharge from hospital indicating that many discharges were appropriate. However, arrangements were not always as robust for people who were awaiting a package of care to be sourced. People waited longer in hospital to receive packages of care, including those people awaiting admission to a nursing home or receiving domiciliary care, meaning they were at risk of suffering avoidable harm such as hospital acquired infections. Relevant information regarding a person's discharge needs was not always shared.*

- Our analysis showed that people waited longer than people living in similar areas to be transferred to other services such as NHS non-acute intermediate and rehabilitation services. The Department of Health's analysis of delayed transfers of care between February and April 2017 showed the average daily rate of delayed transfers in East Sussex was 24 delayed days per 100,000 population, higher than both the comparator average (18) and England average (14). Our analysis of the reasons reported for delays over this period showed the two main reasons were "awaiting further non-acute NHS care" (which includes waiting for intermediate care and rehab) and "awaiting care package in own home". Both reasons for delay can also be used when there are delays agreeing NHS continuing healthcare packages.
- Updated analysis of delayed transfers of care covering July-September 2017 showed that delays in awaiting further non-acute NHS care had reduced dramatically (from an average daily rate of 7.4 delayed days per 100,000 between February and April 2017 to 2.9 delayed days per 100,000), although reductions in delays in awaiting care packages in the person's own home were not as great (reduced from an average daily rate of 5.6 delayed days per 100,000 to 4.4 delayed days per 100,000). Delays as a result of patient or family choice had increased from 3.5 average delayed days per 100,000 between February and April 2017 to 4.2 average delayed days per 100,000 between July and September 2017, making them the second main reason for delayed discharge.
- From early October 2017 ESBT, C4Y, ESCC and the acute trusts had become involved in daily DToC escalation calls to set up a system-wide approach to decreasing the number of people experiencing delays being discharged from hospital and accessing the right care they had been assessed as needing to keep them safe and promote their wellbeing.
- The daily call addressed discharge plans of patients who were experiencing a delayed transfer of care. The daily calls supplemented a weekly MDT meeting, where more complex discharges were discussed. Ward staff confirmed they were involved in these calls and it was part of their daily business.
- Leaders in the system valued these calls and said they had resulted in good progress recently, and locally shared data confirmed this. While the system had not yet met the targets set in the BCF, recent published DToC data as well as local data provided by the system showed they had made strong progress towards achieving this.
- The percentage of older people in East Sussex requiring emergency readmission once discharged was below the national average at 17% between January and March 2017 compared to the national average of 19%, indicating that in general people were being discharged appropriately.

- However, for people being discharged into their own homes with packages of care, the arrangements were not always safe. Domiciliary care providers told us that communication with the discharge teams was sometimes poor. They also reported there was little support from the hospital social worker once the person was discharged. Domiciliary care workers could not access hospital notes and would need to contact GPs to obtain this information which added to delays for a person's care to be delivered.
- As part of the review we requested information from registered domiciliary care and residential care providers about the information they received when someone was discharged into their care. Although there was a process in place for discharge such as the provision of a discharge summary from clinicians and a support plan for people needing social care, this was not always effectively communicated. Respondents who provided residential and/or nursing care said they received discharge summaries more than half of the time when someone was discharged from hospital into their care, however most of the respondents providing domiciliary care said they received discharge summaries less than 25% of the time.

#### **Are services in East Sussex effective?**

*Those people that did receive reablement services had good outcomes. In 2016/17 90.5% of people aged 65+ who received rehabilitation or reablement services after discharge from hospital were still at home 91 days after discharge, however the number in receipt of these services was below the England average. Patient information needed to be kept up to date so when a patient was transferred to receive care from another service the new provider could provide the appropriate care.*

- The percentage of people in receipt of a reablement service was below the national average. Analysis of ASCOF data showed that the percentage of people aged over 65 discharged from hospital who received rehabilitation or reablement services was 1.6% in 2016-17, which was lower than similar areas (2.2%) and the England average (2.7 %). The system indicated that their poor performance on these measures was a result of data quality issues that they were investigating. During our review, we visited a number of bed based reablement services. Although their Health and Social Care Act 2014 regulations required providers to have a robust process for admission to ensure that they can meet people's needs, in East Sussex these were defined in a way that were restrictive. We were told by operational managers at the reablement services Milton Grange and Firwood House that, as a result, nearly half of referrals were declined.
- When people did receive reablement services they had good outcomes. In East Sussex, ASCOF data for 2016/17 showed that 90.5% of people aged 65+ who received

rehabilitation or reablement services after discharge from hospital were still at home 91 days after discharge. This was higher than similar areas where 81.7% were still at home after 91 days and the England average was 82.5%.

- We were told by staff at the reablement services that assessments by the service would not be started until someone had been deemed medically fit for discharge in case their needs changed while in hospital. This was to avoid multiple assessments being completed for a person. However, this was a risk-averse approach that could be contributing to delays to admission into the service and people remaining in acute services longer than necessary.
- System leaders told us that in the last seven years the spend on the adult social care budget for older people had shifted towards community services which included direct payments. ASCOF data for 2016/17 showed that 25.5% of people in East Sussex aged 65 and over who were accessing long-term adult social care support at the end of March 2017 were receiving direct payments. This was above the England average of 17.6%.
- Conversely, analysis of NHS England data on NHS funded continuing healthcare showed in the first quarter of 2017/18 that the number of people in receipt of continuing healthcare direct payments and personal health budgets was below the England average in each of the three CCG areas operating in East Sussex. People who lived in the High Weald Lewes Havens CCG area were most likely to receive personal health budgets or direct payments at 3.29 per 50,000 people. In the Eastbourne, Hailsham and Seaford area, 3.14 people per 50,000 received direct payments or personal health budgets and the number was lowest in the Hastings and Rother CCG area at 2.61 per 50,000. These were all lower than the England averages of 5.82 people per 50,000 receiving personal health budgets and 3.63 per 50,000 receiving those as direct payments. As a result, people funded through continuing healthcare were not always being given opportunities to manage their care in the way that they chose once they returned from hospital.
- Residential and domiciliary care staff did not always understand people's needs to ensure that they received effective care and treatment on return from hospital. Domiciliary care providers reported that adult social care support plans were not always updated on discharge, or were incorrect. They suggested that this may be because assessments were no longer undertaken by social workers. There was not a trusted assessor scheme in place, one of the best practice measures suggested in the high impact change model, although work was underway to develop this role.

### **Are services in East Sussex caring?**

*We saw a strong commitment among operational staff to delivering care with a person-centred approach when managing how people returned to their usual place of residence or to step down*

*care. People who used services, their families and carers told us that written communication was sometimes difficult to understand because of the overuse of acronyms.*

- During our visits to A&E and discharge services we observed staff who were committed to facilitating the journey for patients to other services or the patient's own home as comfortably as possible and to maintaining people's privacy and dignity. We saw staff expediting transport for patients when it was delayed and then arranging for hot meals when the wait had gone over a mealtime.
- Staff spent time with patients, families and carers to find out if there was any further information they required. This included information about their conditions, any equipment they required and access to voluntary services providing social and emotional support.
- It was highlighted during the focus group meeting with primary care staff that there were too many acronyms in hospital discharge letters, making it difficult for patients, families and their carers to understand. This was confirmed when we reviewed records as part of our case tracking and when we dip sampled patients records.

#### **Are services in East Sussex responsive?**

*Delays in discharges were commonly a result of delays in continuing healthcare assessments and a lack of community health and social care support, including reablement beds, community care packages and nursing home beds. Some policies and systems that were in place to enable a timely return for people to their usual place of residence or an alternative setting were not always followed and delays in starting discharge planning meant some people had a negative experience.*

- A Continuing Healthcare Improvement Review was completed by ESBT in September 2017 and shared with the system. It recognised that there had been delays in completing CHC assessments for people in East Sussex with less than 40% being completed in the 28-day timescale set out by NHSE in April 2017 and more than expected being completed in an acute hospital setting. The reasons behind this were identified as a staff shortage across both ESBT and C4Y transformation programme teams which had since been resolved. This had resulted in a backlog of assessments which contributed to delayed discharges from hospital.
- Our analysis showed that between February and April 2017 a higher number of delayed transfers of care were attributable to the NHS than were attributable to social care in East Sussex. The main reasons recorded for delayed transfers in East Sussex over this period were awaiting further NHS care including, intermediate care and rehabilitation (averaging 7.4 delayed days per day), awaiting care package in own home (averaging 5.6 delayed

days per day), patient or family choice (averaging 3.5. delayed days per day) and awaiting nursing home placement or availability (averaging 2.8 delayed days per day).

- Following the Continuing Healthcare Improvement Review many actions had been put in place to address delays which included the recruitment of an additional four nurse assessors with administration support and the provision of additional training to ward staff to support the assessment process, particularly around the Mental Capacity Act.
- With this additional support, an agreement had been made that all CHC assessments would be completed in 14 days in an acute setting and 28 days in a non-acute setting. Progress was to be monitored by the East Sussex Performance & Delivery Committee and at the CHC monthly performance meeting. At the time of the review this work had only very recently started and it was not possible to evaluate the results.
- The discharge to assess process is part of the high impact change model which is a programme developed to support local health and social care systems to reduce the time people spend in an acute hospital, at the point that they no longer need acute care. Discharge to assess had been introduced in front door services in hospital, A&E and Clinical Decision-making Units (CDU) serving East Sussex. Additional funding was agreed during our review to roll out the programme hospital wide.
- During our discussions with domiciliary care providers many people reported that communication with the discharge teams did not always work well. They described times when DCA workers had been told of an approximate discharge time for patients and had waited for the person to arrive home. However, they had not arrived and it was difficult to contact the hospital social worker. Also, the DCA was not always provided with discharge notes from the hospital, as the process in place for the provision of discharge information was not always followed, and they had to access these via the GP.
- There was a lower percentage of patients discharged from hospital at weekends in East Sussex (18.5 % of patients in East Sussex, which is below 13 of East Sussex's comparator areas). One of the factors that may have contributed to this, particularly in the C4Y area, HWLH, was that community health services were not available to provide care in people's own home (e.g. intravenous medication) at weekends.

## Maturity of the system

### What is the maturity of the system to secure improvement for the people of East Sussex

System leaders had a clear shared vision that was being developed through two place based strategies which sat within the wider STP footprint. Although the strategies were aligned with local commissioning intentions, the joint leadership to operationally develop the strategic vision at a system level was not yet fully developed and the two strategies were at difference stages of maturity.

Governance structures were aligned around the two strategic transformation programmes. Each board had shared membership of health and social care representatives which also ultimately reported to the Health and Wellbeing Board and East Sussex County Council cabinet members. However, the Health and Wellbeing Board lacked rigour and was not able to hold to account the leaders of the local transformation strategies.

- There were some cross boundary and interagency initiatives in place, however there was not yet a clear system culture that supported integrated working, with some agencies and staff showing a limited understanding of how health and social care services could support each other. Following recent changes in leadership across the system, including the chair of the STP, relationships now need to become embedded. There were indications particularly from the relational audit that there was a lack of understanding between frontline staff working in different organisations.
- Although there had been some good analysis to identify the needs of people living with dementia to shape the structure and supply of the market, there was no overarching narrative to describe the needs of older people in East Sussex. Owing to the high numbers of self-funders in the local area, system leaders had limited influence on the provider market and although system leaders had worked collaboratively to set out a strategy to address this, they had not yet begun the work to address this.
- The two transformation strategies were at early stages of maturity regarding the collaborative use of resources. In ESBT an alliance agreement was in place to provide flexibility in the use of resources to pave the way for future models of integrated care. Although there were some pooled budgets in place, commissioning was not fully integrated across health and social care and financial pressures were cited as a barrier to full partnership working.
- There was not a clear system-wide approach to the development of an integrated

workforce. The workforce development strategies across the two transformation footprints were not aligned and were at different stages of development which would impact on members of the workforce who managed across both areas. However, this was being managed by the local authority workforce development leads who worked to ensure, as far as possible, a consistent approach. ESBT leaders were working with communications to develop staff expectations and understanding around integration.

- The sharing of records and information across the system was challenging and work to address this within the two strategic transformation programmes was at early stages with the ESBT having slightly more developed systems such as a shared portal to view some basic patient information. The digital strategy was at the early stage of rollout with a plan for a fully shared and accessible patient record due for completion in 2020.
- There was not a system-wide approach to prevention and people living in East Sussex did not have the same access to multi-agency preventative services and crisis response provision such as access to GPs and fall services, as these were commissioned differently within ESBT and C4Y. Leaders were focusing on developing alternatives to bedded care so that people could remain independent in their own homes for longer and there was good integrated working across both areas for people on frailty pathways. More work was needed to develop a whole systems approach to preventative services.



## Areas for improvement

### We suggest the following areas of focus for the system to secure improvement

- Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements across ESBT and C4Y.
- The Health and Wellbeing Board would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and service improvements are delivered, and to ensure whole system integration.
- Work is required to ensure that there is a JSNA for older people which is fit for purpose and can be used to inform strategic commissioning of services across East Sussex.
- There needs to be a system-wide response to effectively managing and shaping an affordable nursing home market and increasing domiciliary care capacity.
- Work is required to improve access to step-down, reablement and intermediate care facilities across East Sussex through the review of admission criteria
- A review of IT interconnectivity should be completed to ensure appropriate information sharing and a more joined up approach to IT communication is established across health and social care services.
- Work towards fully incorporating principles of the High Impact Change Model, particularly discharge to access and the trusted assessor model, needs to be prioritised across the system.
- Seven-day working and referral pathways should be aligned across the system to make the systems and process consistent across the East Sussex footprint.
- Work should be undertaken to share learning between staff across the system rather than at an organisational level.
- Discharge processes need to be reviewed to ensure information is communicated with all involved partners across the system, including families and carers.