West Sussex Health and Social Care System

“Between Hospital and Home”
Our Strategy for Sub-Acute Care

Safe, high quality, integrated and sustainable services – delivering care where it’s most needed

July 2013
EXECUTIVE SUMMARY v7.3 Final
Foreword

About this document
This document represents the conclusion of joint work undertaken between February and June 2013 to develop a Sub Acute Care Strategy for West Sussex. We define “sub-acute care” as health and social care services for the population where in-hospital acute care is not the best way to provide care.

What we commit to doing
As health and social care commissioners, we commit to:

- Deliver a more coordinated model of care, with citizens experiencing support structured around them, avoiding complicated and wasteful duplication
- Ensure that people are supported in ways that evidence shows delivers the best outcomes – in home and closer to home settings where appropriate
- Deliver the best possible value (improved outcomes per Pound spent) for the West Sussex population from available funding (both ongoing allocated budgets for the population, and transformational funding such as NHS Support for Social Care Funds in the short term term).

Why are we doing this now?
In an emergency situation, people need acute care in an acute hospital. Clinical evidence is becoming stronger that in many cases, where appropriate, caring for people closer to home can achieve better health and social outcomes.
Foreword

We recognise that a number of projects have been set up aimed at improving patient care, shifting care closer to home and trying to avoid unplanned acute hospital admissions. However symptoms of system failure persist – including high rates of unplanned admissions to acute hospitals and long term care homes, as well as feedback from citizens, patients, carers and care professionals that things could be much better.

In addition to this, unplanned hospital admissions (which, as described above, clinical evidence suggests may not be the best way to care for a significant proportion of these people) are also contributing to a collective financial challenge for West Sussex CCGs of £37.6million*.

How is this different?

Despite some significant efforts and the dedication of our professional staff, attempts to change the way care and support is provided to the people of West Sussex have been piecemeal and fragmented. The different NHS and social care organisations have sought to solve the challenges they perceive.

This West Sussex Sub Acute Care Strategy sets out a single, clear description of how – based on clinical evidence, professional expertise and local knowledge – we expect health and social care services to develop.

Implementation of this strategy

This strategy is a description of how we plan to provide this care in future. It includes a number of recommendations (based on evidence and best practice) that describe how sub acute care will be delivered.

The successful implementation of this strategy is essential to the long term provision of safe, high quality and sustainable services for our population.

However, we recognise that there are local circumstances, and that implementation must be sensitive to local needs. Implementation will be local – with detailed business cases being developed to implement the strategy in ways that are most appropriate to the local populations and provider landscapes in the North and South of the county.

Health and social care professionals across West Sussex have been engaged in the development of these recommendations, and further engagement and consultation will form a key part of this work going forward.

*Source CCG Operating Plans 12/13
Foreword

Our personal commitment to this strategy
We, the leaders of health and adult social care commissioning in West Sussex, agree with the direction of travel of this strategy. We commend it to our organisations.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Mike Sadler</td>
<td>Director of Health and Social Care</td>
<td>West Sussex County Council</td>
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<td></td>
<td>Commission</td>
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<tr>
<td>Dr Amit Bhargava</td>
<td>Clinical Chief Officer</td>
<td>Crawley Clinical Commissioning Group</td>
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<tr>
<td>Dr Katie Armstrong</td>
<td>Clinical Chief Officer</td>
<td>Coastal West Sussex Clinical Commissioning Group</td>
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<tr>
<td>Dr Minesh Patel</td>
<td>Clinical Chair</td>
<td>Horsham &amp; Mid Sussex Clinical Commissioning Group</td>
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<td>Sue Braysher</td>
<td>Accountable Officer</td>
<td>Horsham &amp; Mid Sussex Clinical Commissioning Group</td>
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<td>and Crawley Clinical Commissioning Group</td>
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SECTION 1
Executive Summary
Executive Summary

1.1 Background

There is an increasing evidence base internationally that where patients do not need the level of support only available in an acute hospitals, they can achieve better health and social outcomes being cared for closer to home. People can be seen earlier and with more context of their wider health and social situation, helping to prevent crises, or catching them before they escalate – and then enabling them to return home again sooner. This is frequently described in relation to frail and older people – where hospital admissions can result in loss of independence, confidence and the risk of complications. However, it equally applies to the whole population – with health and social care services being delivered in the community where possible and hospitals being preserved for the most urgent cases.

Significant efforts have been made by health and social care organisations in West Sussex to move towards delivering care in these ways. However:

• These initiatives have typically been fragmented, with different organisations seeking to improve their own services without a wider co-ordination of plans and services

• Feedback from patients, citizens, carers and care professionals indicates that services remain overly complex, don’t necessarily work well together and are not delivering the best care

• Significant numbers of patients are still receiving care in hospitals that could and should be delivered closer to home. This is putting significant (and unnecessary) pressure on our hospitals – with unprecedented A&E attendances at Worthing, East Surrey and St Richards hospitals. This is not sustainable and has the potential to risk outcomes for patients experiencing emergencies.

• Care homes are frequently used as a reactive response to urgent situations

• A combination of the duplication of services and unnecessary admissions to hospital is contributing to significant financial pressures with CCGs in West Sussex currently facing a collective financial challenge of £37.6m*. Further still, to date, new service initiatives have been developed without a clear, overarching strategy for how sub-acute services should be provided and commissioned across the county.

*Source CCG Operating Plans 12/13
Executive Summary

1.2 This strategy

A renewed commitment to deliver

Changes in health and social care commissioning and leadership present an opportunity to transform the way care is delivered.

In March 2013, NHS Horsham and Mid Sussex CCG, NHS Crawley CCG, NHS Coastal West Sussex CCG and West Sussex County Council (WSCC) agreed to work together, with the help of PwC, to develop this Sub Acute Care Strategy for the county.

This strategy sets out a description of how sub acute services will develop so that they:

- Deliver a more integrated model of care, with citizens experiencing support structured around them, avoiding complicated and wasteful duplication.
- Ensure that people are supported in the ways that evidence shows delivers the best outcomes – in home and closer-to-home settings where possible.
- Deliver the best possible value (improved outcomes per Pound spent) for the West Sussex population from available funding (both ongoing allocated budgets for the population, and transformational funding such as NHS Support for Social Care Funds in the short term).

Governance

The West Sussex Joint Commissioning Strategy Group (JCSG) agreed the scope for the sub acute strategy, and has led its development and approval.

JCSG determined that whilst the sub acute strategy would set a number of high level recommendations at county level, the implementation of the sub acute strategy should be owned and delivered locally in ways that are most appropriate to the local populations in different localities in West Sussex.

1.3 Approach

Design principles

In developing the strategic recommendations for health and social care services, the following overarching design principles were agreed by JCSG:

1. Citizens and patients in the West Sussex area should all experience the same optimum patient journeys* through sub acute care regardless of where they live in the county.
2. Patients in West Sussex should all benefit from an integrated model of health and social care, with patients experiencing support structured around them, avoiding complicated and wasteful duplication.

*Optimum patient journeys are described in more detail in Section 4.
Executive Summary

3. Health and social care commissioners should commission services which support people in ways that evidence shows delivers the best outcomes (for example that care in home and closer-to-home settings can deliver better outcomes)

4. Simplification and standardisation has been shown to achieve the same/greater patient outcomes at a reduced cost/ greater efficiency and should be pursued if there are not compelling local reasons for variation

5. Transformational funding (NHS Support for Social Care Funds) should be used to deliver optimal change and value (improved outcomes per pound spent) for the West Sussex population

A common language for health and social care in West Sussex: the “6 Box Model of Care”

Health and social care services are complex – with patient / citizen needs – and the services needed to support them – forming a continuum rather than discrete services.

Historically, the different roles and services of different organisations (social care, community healthcare trusts, primary care, hospital trusts, etc.) has frequently been used to structure strategy on services. However, this is not helpful as it does not reflect patient / citizen needs or support the development of integrated care.

In order to develop strategic options, JCSG agreed to use a single framework – referred to as the “6 box model of care” – as a framework to review current provision of sub acute care services and set the future sub acute strategy. This model of care identifies the services and support required throughout the whole cycle of a patient’s care.
### Executive Summary

1.4 Current position: West Sussex sub acute health and social care service

A series of service level meetings and data requests took place to gain a comprehensive understanding of current sub acute services.

These services were then mapped against the 6 box model of care – including key metrics such as spend, provider, activity, outcomes and performance indicators. A detailed description of all sub-acute health and social care is provided in Section 3 of this document.

The total spend on sub acute care services (as defined in the strategy and associated PID) is £137.3m*. Allocated to the Six Box Model of Care, this spend is as follows:

- **1. Healthy Living and Wellbeing** - services in this area cost £12.9m and largely relate to spend on podiatry care and public health spend on providing health advice and screening.
- **2. Proactive Care** - services in this area cost £9.3m and largely relate to spend on the 2 proactive care programmes in the North and South of the county.
- **3. Crisis Intervention, Admissions Avoidance** - services in this area cost £12.2m and largely relate to spend on the urgent treatment centre at Crawley Hospital as well as One Call and One Team services in the North and South of the county.
- **4. Bedded Care (sub acute)** – total spend in this area is £26.5m and largely relates to community beds provided by Sussex Community Trust and step up/ down beds in the North and South of the county.
- **5. Discharge to Assess** - total spend in this area is £16.3m and largely relates to intermediate care teams in the North and South of the county.
- **6. Maintaining Independence** - services in this area cost £60.2m and largely relate to spend on domiciliary care, day care, direct payments and community nursing.

**Key challenges facing the current services**

Quantitative and qualitative analysis (in the form of interviews and questionnaires with a range of stakeholders) was carried out to identify the key challenges that exist in the West Sussex sub acute care economy. The following key challenges were identified:

- Reducing the number of unnecessary non elective admissions and making optimum use of sub acute capacity (e.g. proactive care, step up beds)

*Sources: Sussex Community Trust Budget 12/13, Individual CCG budgets 12/13, Joint Commissioning Unit Budget 12/13, West Sussex County Council Budget 13/14.*
Executive Summary

• Reducing the number of admissions to long term care homes
• Reducing patients length of stay in hospital (community and acute) and effectively supporting discharge (high level analysis indicated there was an opportunity to reduce the beds required at the 3 community hospitals analysed)
• Promoting effective understanding of the service available and how people access these services (e.g. through One Call – single point of access)
• Integrating care for patients and reducing the organisational boundaries that exist which result in duplication and fragmentation of services
• Improving the quality of care and outcomes for patients
• Treating older people with respect and dignity
• Closing the existing West Sussex CCG’s financial deficit of £37.6m, and managing WSCC’s reduction in funding
• Making optimum use of the recent transformation funding (NHS Support for Social Care funds) to address existing challenges

1.5 Future West Sussex Sub Acute Health and Social Care

A number of recommendations were then made (at the six box level and system wide level) to address the challenges that currently exist in the West Sussex health and social care economy.

The future model of care is described in four key ways:

A. Overall sub acute care strategy – by 6 box model area
• Example descriptions of patient / citizen journeys
• Strategic decisions taken by JCSG

B. West Sussex immediate sub acute care priorities
• Based on the immediate challenges facing West Sussex – the priority areas of focus and attention

C. Local area priorities
• The local priorities defined by each of the Clinical Commissioning groups

D. System enablers
• The underlying changes in areas such as contracting models
### Executive Summary

1.5A Overall sub acute care strategy – by 6 Box Model of Care area

<table>
<thead>
<tr>
<th>Healthy living &amp; wellbeing</th>
<th>Proactive care</th>
<th>Maintaining independence</th>
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**Example patient journey**

Annie is an 80 year old lady who lives alone. She pays for help with her cleaning and Jane, her daughter, prepares most of her meals. She has COPD which she manages with her inhalers. Through the risk stratification process undertaken by her GP surgery, Annie is assessed as a tier 1 patient as she has had a number of admissions to hospital in the last 12 months. The proactive care team review her case and decide to assign a community nurse as Annie’s case manager (given that her primary need is a medical one). The community nurse contacts Annie and arranges a visit, and Annie’s health and care needs are assessed by the nurse with her daughter, Jane, present. Together they arrange a care plan which includes Annie regularly recording when she has taken her inhalers, what to do if she feels more breathless, what additional help at home needs to be provided when her daughter Jane is away and some strength and balance training arranged by Age UK in her local village hall. Her personalised care plan is recorded in her electronic record and this is visible to all care professionals on a single shared IT platform. Her case manager agrees to phone her to see how she is progressing.

Two weeks later at 2pm Annie becomes increasingly breathless and rings her case manager. The case manager tells Annie to take her brown inhaler four times a day, and check the colour of her phlegm. The phlegm is green, so Annie is advised to take the oral corticosteroids and antibiotics (that had been pre-prescribed for her in case of deterioration). Annie’s condition is managed at home through self medication and through the advice and support of her case manager. Both Annie and her daughter feel more comfortable that they can manage if she deteriorates again.

If Annie became increasingly breathless in the middle of the night, she would call 111. 111 would route her to One Call, who through their access to her personalised care plan, would advise Annie in the same way her case manager did.

**Key features of the new model of care:**

- Risk stratification
- Proactive care MDT team case management and self management
- Strength and balance training
- Integrated Information Management and Technology (IM&T) systems
## Executive Summary

### 1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

- **Healthy living & wellbeing**
- **Proactive care**
- **Maintaining independence**

<table>
<thead>
<tr>
<th>6 Box Model Area</th>
<th>Strategic intentions</th>
<th>Scale / complexity</th>
<th>Impact</th>
<th>Planned go-live</th>
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<tbody>
<tr>
<td><strong>Maintaining independence</strong></td>
<td>MI 1: Commission a single integrated (health and social care) rehabilitation and reablement service*</td>
<td>H</td>
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<td>Oct 2015</td>
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<td></td>
<td>MI 2: Commission a single integrated (health and social care) domiciliary care framework</td>
<td>H</td>
<td>H</td>
<td>Apr 2015</td>
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<td>MI 3: Commission domiciliary care as to incentivise providers to maintain independence, and work with all private market providers to promote the outcome of independence</td>
<td>M</td>
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<td>Apr 2015</td>
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<td></td>
<td>MI 4: Increase number of people receiving personalised social care support</td>
<td>M</td>
<td>H</td>
<td>Apr 2014</td>
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<td></td>
<td>MI 5: Roll out comprehensive geriatric assessments for all elderly patients either identified as high risk through risk stratification or who have been admitted to hospital</td>
<td>H</td>
<td>M</td>
<td>Jul 2014</td>
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<td></td>
<td>MI 6: Continue promotion of the memory assessment service that is already available in West Sussex (The memory assessment service has been in place since September 12)</td>
<td>M</td>
<td>M</td>
<td>Ongoing</td>
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<tr>
<td><strong>Proactive care</strong></td>
<td>PC 1: Continue with existing plans to develop a risk stratification tool in Coastal (South) and refine use of existing tool in the North</td>
<td>M</td>
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<td>Jan 2014</td>
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<td></td>
<td>PC 2: Conduct a review of the risk stratification tools used by North and South with the aim of calibrating certain stratification criteria to ensure that they are neither too wide (therefore identifying very low risk patients) or too narrow (excluding patients who would benefit).</td>
<td>M</td>
<td>H</td>
<td>Apr 2014</td>
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<td></td>
<td>PC 3: Continue with existing implementation plans for MDTs.</td>
<td>L</td>
<td>H</td>
<td>Apr 2014</td>
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<td></td>
<td>PC 4: Commission anticipatory care plans as a mandatory part of admission to care homes.</td>
<td>M</td>
<td>H</td>
<td>Jan 2015</td>
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<td></td>
<td>PC 5: Create clear business cases for each Proactive Care programme,</td>
<td>M</td>
<td>M</td>
<td>Nov 2013</td>
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1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

Crisis intervention and admission avoidance

<table>
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<th>Example patient journey</th>
<th>Key features of the new model of care:</th>
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</table>
| Fred is an 85 year old who had a stroke 10 years ago, and since his wife (his carer) died 8 years ago, he has been living in a care home. The care home, in consultation with Fred, put in place an anticipatory care plan for Fred, which was a mandatory part of his admission to the care home. This care plan has been regularly updated with input from Fred’s local GP. Fred suffers a crisis in the care home, developing cellulitis in a small leg ulcer. This leaves Fred with a fever, and feeling confused. In line with his anticipatory care plan and the care home escalation criteria and protocols, the care home contacts the One call service to seek advice and support. ONE team review the case and arrange for a district nurse to go to the care home to review Fred. The nurse also talks to Fred’s GP, and agrees to manage Fred’s condition with IV antibiotics. The nurse continues to visit Fred to administer the IV and supports the care home staff to ensure Fred returns to his previous level of function. Fred’s condition improves and he has happy that he didn’t have to be moved to hospital and away from his care home where he feels comfortable. | • Anticipatory care plans on admission to care homes  
• Single point of access – One Call/ One Team  
• Specialist nursing support to care homes |

Notes
Throughout this document, the term “One Team” is used a generic term for the admission avoidance / crisis intervention teams known locally as Admission Avoidance teams (AATs) in the North of the county and Rapid Assessment Intervention team and supporting services (RAIT) in the South of the county.
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### 1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

#### Crisis intervention and admission avoidance

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<tr>
<th>6 Box Model Area</th>
<th>Strategic intentions</th>
<th>Scale / complexity</th>
<th>Impact</th>
<th>Planned go-live</th>
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<tr>
<td>Crisis intervention and admission avoidance</td>
<td>CI 1: Create single integrated contact point for health and social care professionals (referred to as One Call for the purposes of this strategy)</td>
<td>H</td>
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<td>Apr 2015</td>
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<td></td>
<td>CI 2: Make One Team a 24 hour service</td>
<td>M</td>
<td>H</td>
<td>Apr 2015</td>
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<tr>
<td></td>
<td>CI 3: Continue with measures to address current One Call/ One Team performance and system issues</td>
<td>M</td>
<td>M</td>
<td>Apr 2014</td>
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<tr>
<td></td>
<td>CI 4: Put in place clear escalation criteria and protocols in care homes, along with suitable training and education on their use</td>
<td>M</td>
<td>M</td>
<td>Apr 2014</td>
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<td></td>
<td>CI5: Coastal (South) to implement rapid access medical units at main acute provider. North to continue with existing implementation plans for Rapid Access Medical Unit (RAMU) at Princess Royal Hospital</td>
<td>M</td>
<td>M</td>
<td>Apr 2015</td>
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</table>
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1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

Bedded care (sub acute)

Example patient journey

| Rose is an 82 year old lady with a social care package. Her daughter visits her and finds Rose on the floor, confused. The daughter calls 999 and ambulance is dispatched to Rose’s home. The paramedic assesses Rose and decides that Rose is not in any immediate danger or risk, however remains unclear as to why she has fallen. The paramedic calls the ONE call service for advice, they discuss the case and advise the paramedic to take Rose to a step up community bed that their systems tell them is available at Midhurst Community Hospital. |
|---|---|
| At Midhurst, Rose is observed overnight and diagnostic tests are carried out. Rose is then discharged the next day back to her home, as the diagnostic tests did not show any areas for concern. The One team assess Rose and through One Call arrange for Rose’s social care package to be increased to 4 visits instead of 2 for the next week. One Call also arrange for the falls team to assess potential hazards at Rose’s home and for the Handyman Service to fit grabs rails and non slip mats in her house to help to prevent any future falls. |

Key features of the new model of care:

- Single point of access - One Call/One Team
- Centralised control of beds by One Call
- Step up care – bedded and at home
- Home adaptations
- Integrated IM&T system

Notes
Throughout this document, the term “One Team” is used a generic term for the admission avoidance / crisis intervention teams known locally as Admission Avoidance teams (AATs) in the north of the county and Rapid Assessment Intervention team and supporting services (RAIT) in the South of the county.
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### 1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

#### • Bedded care (sub acute)

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<tr>
<th>6 Box Model Area</th>
<th>Strategic intentions</th>
<th>Scale / complexity</th>
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<th>Planned go-live</th>
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<tbody>
<tr>
<td>Bedded care (sub acute)</td>
<td>• BC 1: One call to control and coordinate all sub acute bed use across the county. Acting as a single control in the system</td>
<td>H</td>
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<td>Apr 2014</td>
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<td>• BC 2: One Call to control and coordinate all sub acute beds and promote bed use for step up purposes with a minimum of 20% of beds to be used for step up care</td>
<td>H</td>
<td>H</td>
<td>Apr 2014</td>
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<td></td>
<td>• BC3: Commissioners to make sure that community bed resources are utilised efficiently and that the number of beds is the right size for the needs of the population. The immediate step towards achieving this is to make it mandatory for all community hospital sites to record ICD10 data, so that benchmarking analysis of activity can be carried out.</td>
<td>H</td>
<td>H</td>
<td>Apr 2014</td>
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<td></td>
<td>• BC 4: Develop clear service specifications for sub acute beds* across the county</td>
<td>M</td>
<td>M</td>
<td>Aug 2013</td>
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*sub acute beds defined as beds based in community hospitals or beds commissioned from care homes which provide step up/step down care, short term rehabilitation or reablement.
## Executive Summary

1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

### Discharge to assess | Maintaining independence

**Example patient journey**

<table>
<thead>
<tr>
<th>Key features of the new model of care:</th>
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<tbody>
<tr>
<td>• Integrated IM&amp;T system (linking 111 and One Call)</td>
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<tr>
<td>• Single point of access - One Call/One Team</td>
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<tr>
<td>• Early supported discharge</td>
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Bill is 76 and lives at home with his wife, he has had diabetes for the last 8 years which he has controlled well through self management. One night Bill starts experiencing severe abdominal pains and begins vomiting. His wife calls the 111 service who arrange an ambulance to be sent to collect Bill and take him into hospital. At this point the 111 service also log the admission and prepare a discharge process through One Call. Bill goes into hospital and has abdominal surgery on a bowel obstruction that evening. Bill then remains in hospital for 5 days following his surgery. during his recovery period.

However, during his post surgical recovery period, Bill’s previously well controlled diabetes becomes uncontrolled with his blood sugar levels becoming unstable. Although the One Call planned to call the hospital 5 days after admission (a process triggered as part of his wife’s initial call to 111), the ward team call One Call to arrange an early supported discharge, given that Bill is surgically fit to discharge. An ambulance is arranged by One Call to take Bill back home to his wife, and as part of the early supported discharge a diabetes specialist nurse visits Bill within 2 hours of his arrival back home. The specialist nurse takes Bill and his wife through the management of his diabetes, including a one week care plan, a meal plan, advice on what to do if his insulin levels spike and also an ongoing contact number. Bill was not originally flagged up on the risk stratification tool as requiring proactive care intervention. If he had been, his assigned case manager (community nurse) would have taken on responsibility for ‘reaching’ into the ward and coordinating Bill’s discharge.

**Notes**

Throughout this document, the term “One Team” is used a generic term for the admission avoidance / crisis intervention teams known locally as Admission Avoidance teams (AATs) in the north of the county and Rapid Assessment Intervention team and supporting services (RAIT) in the South of the county.
### Executive Summary

1.5A Overall sub acute care strategy – by 6 Box Model of Care area (cont.)

- **Discharge to assess**

<table>
<thead>
<tr>
<th>6 Box Model Area</th>
<th>Strategic intentions</th>
<th>Scale / complexity</th>
<th>Impact</th>
<th>Planned go-live</th>
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</thead>
<tbody>
<tr>
<td><strong>Discharge to assess</strong></td>
<td>• DA 1: Engage with providers to develop an early supported discharge model for all patient categories</td>
<td>H</td>
<td>H</td>
<td>Apr 2015</td>
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<tr>
<td></td>
<td>• MI 1: Commission a single integrated (health and social care) rehabilitation and reablement service</td>
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<td>Oct 2015</td>
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<td></td>
<td>• DA 2: Trigger discharge planning process at point of admission</td>
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<td>Apr 2015</td>
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</table>

**Maintaining independence**
Executive Summary

1.5B West Sussex immediate sub acute care priorities

The previous slides set out the strategic intent for sub-acute services in West Sussex. These represent significant changes to the health and social care delivery system, and realistic implementation timescales have been assigned. The majority of changes are likely to have been completed by April 2015 – with other initiatives coming on stream earlier or later (see implementation plans for detail).

However, the commissioners recognise that there are immediate pressures and challenges that will continue to affect the health and social care system during the transitional period (i.e. between now and April 2015). These pressures reflect:

- Experience over the winter of 2012/13 with increased unplanned activity in acute hospitals, primary care and other parts of the system.
- The financial context within which health and social care systems will operate as a result of the 2013 government spending review, namely:
  - Planned 10% reduction in local authority funding and, as a result, adult social care spending.
  - Ring-fenced (but flat) NHS funding allocations.
  - The £3bn fund to support the development of integrated care.

The co-ordination of urgent care will come under the governance of the system-wide Urgent Care Boards. However as part of the strategy for sub-acute health and social care, the following four immediate sub acute care priorities have been identified:

1. Planned escalation for winter 2013/14 and 2014/15

Through the Urgent Care Boards, the commissioners will support planned escalation of activity – co-ordinated across primary, social, community and acute care. This will comprise:

- Weekly monitoring of key performance data (A&E admissions, GP waiting times, ambulance redirects, social care response times, etc.)
- Agreed mechanisms for rapid changes in delivery of service (including performance management) in response to specific needs – across primary, acute, social and community care.
- A partnership agreement between local acute, community and adult social care providers to work together to escalate, if required to a single co-ordinated patient flow management across acute, community, social care and nursing home beds – with a single point of control of all bed stock, supported by risk pooling arrangements. Commissioners will be responsible for setting the framework and trigger points at which this partnership agreement would come into play.
Executive Summary

1.5B West Sussex immediate sub acute care priorities (cont.)

2. Revised use of community healthcare beds
   • An immediate requirement for all community healthcare bed providers to capture ICD10 activity data on patient activity. This is required both to provide data to make decisions on commissioning beds, but also to support the planned winter escalation processes described in (1) above
   • A review of community beds to be carried out in Aug/Sep 2013 to identify and protect capacity for step-up beds available to provide sub-acute inpatient care and diagnostics. The review should also include the options for providing adequate medical cover (GP and / or geriatrician) cover step-up and step down beds.

3. Short-term improvements to existing services
   • Based on the mapping of sub-acute services in this document, a single responsible officer (SRO) to be appointed from both provider and commissioner organisations or each area of the 6 Box Model of Care – for each CCG area.
   • The provider and commissioner SROs will work together to review common services and (pending full re-commissioning of these as integrated services) make linkages between care professionals running the services to ensure co-ordination and appropriate allocation of services to patients with the greatest need (e.g. Common acceptance criteria, shared review of patients, etc.)

4. Co-ordinated approval, agreed requirements and monitoring for tactical investment decisions (e.g. those funded through Transformation Funds)
   • All requests for new / additional services or capacity will be required to complete a business case, and assessed through the new Business Case Evaluation Tool
   • Approval of any such business cases will be subject to:
     - The Business Case Evaluation Tool showing a robust and sufficient level of detail and planned impact
     - Mapping of the new service / capacity against service maps to demonstrate lack of duplication
     - The approval of JSCG
     - Notice to any care provider that is expected to see a reduction in activity for them to review, comment and monitor impact of the service
   • All such business cases will be monitored against planned KPIs, with rights reserved to withdraw funding if target outcomes are not achieved

The delivery of these four priorities will require cross-organisation working, and the JCSG will expect and monitor such working
The JCSG agreed that local ownership and delivery are critical to the successful development of sub acute care services – and that a single West Sussex model of care is not always appropriate. This reflects variations in population, demography, location and type of current health and social care provision and other factors.

Based on the overall strategy direction set out in section 1.5A previously, each CCG has put forward their priority areas from the initiatives identified. The following sections set out the strategic recommendations that have been prioritised by each CCG. For each strategic recommendations comment on the scale of change required, the impact of the change, and the implementation timescale (taken from the high level implementation plan on pages 19 and 20) has been included.
Executive Summary

1.5C Local area priorities - Coastal West Sussex Clinical Commissioning Group

“Our key priorities will be to enable people to remain independent in their own homes for as long as possible through more co-ordinated commissioning of reablement and rehabilitation services, home care and personalised social care support. We will also simplify urgent access to health and social care services through the creation of a single co-ordinated contact point for health and social care professionals (building on the existing One Call service). Finally, building on our previous review of community beds, we will analyse current use of community beds to make sure that the number of beds is right for the needs of our population and that beds are being used efficiently.”

<table>
<thead>
<tr>
<th>Strategic intentions for CWS CCG – priority elements of the West Sussex Sub Acute Care Strategy</th>
<th>Scale / complexity</th>
<th>Impact</th>
<th>Planned go-live</th>
</tr>
</thead>
</table>
| 1. **Maintaining Independence**  
- MI 1: Commission a single integrated (health and social care) rehabilitation and reablement service*  
- MI 2: Commission a single integrated (health and a social care) domiciliary care framework  
- MI 3: Commission domiciliary care as to incentivise providers to maintain independence, and work with all private market providers to promote the outcome of independence  
- MI 4: Increase number of people receiving personalised social care support | H | H | Oct 2015 |
| 2. **Crisis Intervention, Admissions Avoidance**  
- CI 1: Create a single integrated contact point for health and social care professionals (referred to as One Call for the purposes of this strategy) | H | H | Apr 2015 |
| 3. **Bedded Care (Sub Acute)**  
- BC 3: Make sure that community bed resources are utilised efficiently and that the number of beds is the right size for the needs of the population. The immediate step towards achieving this is to enforce that all community hospital sites record ICD10 data, so that benchmarking analysis can be carried out | H | H | Apr 2014 |
## Executive Summary

### 1.5C Local area priorities - Crawley Clinical Commissioning Group

“Our priorities will be to develop co-ordinated, rapid and safe community based services, which provide an alternative to emergency hospital admission and are available 24/7. We will review the current supply and use of community beds and will support care home providers in Crawley to plan for, and respond better to, the changing needs of their residents during a crisis. We will also work with other health and social care providers to broaden access to Crawley urgent treatment centre and to develop a model for early supported discharge from acute care for all patients.”

### Strategic intentions for Crawley CCG – priority elements of the West Sussex Sub Acute Care Strategy

<table>
<thead>
<tr>
<th>Strategic intent</th>
<th>Scale / complexity</th>
<th>Impact</th>
<th>Planned go-live</th>
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<tbody>
<tr>
<td><strong>Bedded Care (Sub Acute)</strong></td>
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<tr>
<td>• Work with other providers (inc. South East Coast Ambulance Service, GPs, Sussex Community Trust, SPFT, and Social Services) to be able to accept a broader range of urgent care patients with sub acute needs at the Urgent Treatment Centre at Crawley (specific priority for Crawley CCG)</td>
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<td>• BC 2: One Call to control and coordinate all sub acute beds and promote bed use for step up purposes with a minimum of 20% of beds to be used for step up care</td>
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<td>H</td>
<td>Apr 2014</td>
</tr>
<tr>
<td>• BC3: Make sure that community bed resources are utilised efficiently and that the number of beds is the right size for the needs of the population. The immediate step towards achieving this is to enforce that all community hospital sites record ICD10 data, so that benchmarking analysis can be carried out.</td>
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<td>Apr 2014</td>
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<tr>
<td><strong>Discharge to Assess:</strong></td>
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<tr>
<td>• DA 1: Engage with providers to develop an early supported discharge model for all patient categories</td>
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<tr>
<td>• DA 2: Trigger discharge planning process at point of admission</td>
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<td>Apr 2015</td>
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<td><strong>Proactive Care:</strong></td>
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<td>• PC 4: Commission anticipatory care plans as a mandatory part of admission to care homes.</td>
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<td>Apr 2015</td>
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<tr>
<td><strong>Crisis Intervention, Admissions Avoidance (with a focus on support to care homes)</strong></td>
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<tr>
<td>• CI 1: Create a single integrated contact point for health and social care professionals (referred to as One Call for the purposes of this strategy)</td>
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<td>Apr 2015</td>
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<tr>
<td>• CI 2: Make One Team a 24 hour service</td>
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<td>Apr 2015</td>
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<tr>
<td>• CI 3: Put in place clear escalation criteria and protocols in care homes, along with suitable training and education on their use</td>
<td>M</td>
<td>M</td>
<td>Apr 2014</td>
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</tbody>
</table>
Executive Summary

1.5C Local area priorities - Horsham & Mid Sussex Clinical Commissioning Group

“Our key priorities will be to improve community based services that provide a co-ordinated, rapid and safe alternative to emergency hospital admission and are available 24/7. In particular, we will focus on supporting our care home providers in Horsham Mid Sussex to make better use of these alternatives and to plan for, and respond better to, the changing needs of their residents during a crisis.”

Strategic intentions for H&MS CCG – priority elements of the West Sussex Sub Acute Care Strategy

<table>
<thead>
<tr>
<th>Strategic Intention</th>
<th>Scale / Complexity</th>
<th>Impact</th>
<th>Planned Go-Live</th>
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<tbody>
<tr>
<td><strong>1. Bedded Care (Sub Acute)</strong></td>
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</tbody>
</table>
• BC 2: One Call to control and coordinate all sub acute beds and promote bed use for step up purposes with a minimum of 20% of beds to be used for step up care | H | H | Apr 2014 |
| **2. Proactive Care:** |  
• PC 4: Commission anticipatory care plans as a mandatory part of admission to care homes. | M | H | Apr 2015 |
| **3. Crisis Intervention, Admissions Avoidance (with a focus on support to care homes)** |  
• CI 1: Create a single integrated contact point for health and social care professionals (referred to as One Call for the purposes of this strategy) | H | H | Apr 2015 |
|  |  
• CI 2: Make One Team a 24 hour service | M | H | Apr 2015 |
|  |  
• CI 4: Put in place clear escalation criteria and protocols in care homes, along with suitable training and education on their use | M | M | Apr 2014 |
Executive Summary

1.5D System enablers

A number of system enablers have also been identified that are key to enabling the delivery of the recommendations at the six box level. These recommendations are based on best practice.

System Governance

Strong system governance is required to ensure that decision making related to the sub-acute strategy is aligned to the whole system, and that there is coordination and accountability for delivery. However whole system governance must be balanced with local ownership and variations based on local population needs.

It is recommended that the JCSG has responsibility for coordination at the county level and setting the West Sussex sub acute care strategy, outlining certain county wide recommendations. The local CCGs and WSCC should then be accountable for local planning and implementation of these recommendations in ways that are most appropriate for the local population. It is recommended that there are clear linkages between North and South groups where appropriate (e.g. Between the Proactive Care Programme Boards in the North and South for calibration of risk stratification criteria).

Aligning risk and span of control

Current finance and contracting arrangements in West Sussex are fragmented. They vary from volume-driven payments (acute) to block contracts (social care, community healthcare and mental healthcare). These models:

- Leave commissioners at risk of any increases in activity (not only those attributable to external factors such as population growth, but also caused by inefficiency or inappropriate prioritisation)
- Do not sufficiently incentivise providers to deliver the best care in the way commissioners have identified would deliver the best outcomes (or hold them accountable)

The commissioners of West Sussex intend to move towards commissioning models that align accountability for outcomes and cost to the organisations with the ability to influence those outcomes. This will apply to all health and social care commissioning – so that enhanced primary, community, social and hospital care are incentivised to work towards these models.

Evidence from other countries (e.g. Alzira in Spain, Beacon Health in USA) has shown that improved outcomes at sustainable cost can be achieved in this way.
Executive Summary

1.5D System enablers (cont.)

Finance and contracting

In order to align incentives and spans of control, the commissioners will review both the scope and approach to commissioning.

Scope will consider moving from traditional organisation-centric commissioning (i.e. single contracts for LES, community services or hospitals) to patient/citizen centric service categories (e.g. long term conditions, proactive care or urgent care).

The approach will include contract models that incentivise clinical/service outcomes, service user experience and ability to deliver other intended benefits (e.g. reductions in activity / cost elsewhere in the system).

Models may include capitated outcome based incentivised contracts (COBIC).

Leadership, individual and collective behaviour change

Effective leadership and the individual and collective behaviours of staff working across sub-acute care are key enablers to the successful implementation of more integrated models of care.

Meetings with stakeholders across West Sussex provided a number of examples of where there is a lack of co-operation across organisational boundaries and the effect this can have on the patient experience.

Leadership in all organisations within the West Sussex care economy should continue to foster a culture which is centred around the needs of the patient and works towards building a greater degree of trust between staff across organisational boundaries, thereby working in the interest of the health and social care economy as a whole.

IM&T

In West Sussex, information sharing is either hard or impossible between different health and social care organisations due to a lack of an integrated IM&T system. This results in a lack of communication and coordination between services, and in patients not receiving the best possible care.

West Sussex needs to move to a single integrated health and social care IM&T system. The requirements for this will be:

- A single, coordinated point of access to services, across the appropriate channels;
- Access to comprehensive patient / service user information to allow informed decision making;
Executive Summary

1.5D System enablers (cont.)

- Ability to record all actions taken and share this information with other professionals;
- Ability to provide appropriate urgent response quickly and effectively for both medical and social care episodes;
- Effective identification of candidates for early discharge processes to accelerate their discharge to a community setting;
- Ability to provide appropriate community medical and social care services and measure their effectiveness; and
- Access to appropriate risk stratification tools to support targeting of services for people with complex needs.

Performance management

It is intended that local planning takes place to develop the outlined recommendations into more detailed business cases and that the recommendations are implemented locally in ways that are most effective for the local populations in the north and south of the county. Once the recommendations are implemented, it is crucial that dedicated management attention is given to performance management to ensure delivery of the intended benefits and outcomes. In this case, effective performance management can be broken down into two main forms:

1. Enforcing provisions built into contracts
   In order to do this effectively it is essential that:
   - Contracts are constructed clearly (clear scope, KPIs, outcomes etc)
   - There is an ongoing contracts management process in place, (some of this service is likely to be carried out by the CSU)
   - Escalation and enforcement measures are built into contracts and there is the means to act upon these measures as necessary

2. Holding to account through the JCSG
   In order to do this effectively it is essential to have a lead from the JCSG to take responsibility for strategic decision making around any escalation measures, and ensure appropriate action is taken.
Executive Summary

1.6 High Level Implementation Plan (1of2)

1. Maintaining Independence

Programme & Change Management

- WSCC and local (North and South) planning and business case for domiciliary care
- Commission single integrated domiciliary care framework that incentivises independence
- Local (North and South) planning and business case for reablement and rehab services
- Ongoing promotion of memory assessment service + Performance Management and Benefits Realisation

Programme management, PMO & Benefits Realisation

Stakeholder & employee communication and engagement

1.1.1.2.3.4.5.6

2. Healthy living and wellbeing

Programme & Change Management

- Conduct Business Case for North and Coastal (South) Proactive Care Programmes
- Continue with existing plans to identify and implement Risk Strat. tool in Coastal (South) and refine use of existing tool in the North
- Continue with existing MDT implementation plans

Performance Management and Benefits Realisation

3. Proactive Care

Programme & Change Management

- Continue with existing plans to identify and implement Risk Strat. tool in Coastal (South) and refine use of existing tool in the North
- Continue with existing MDT implementation plans
- Commission mandatory anticipatory care plans as part of framework agreement with care homes

Performance Management and Benefits Realisation

IM&T

- Work with private market providers to promote the outcome of independence
- Commission an increased level of personalised social care support
- Conduct training
- Commission an increased level of personalised social care support
- Local (North and South) planning and business case for CGA (including criteria to be part of CGA)
- Performance Management and Benefits Realisation

Finance & Contracting

- Detailed design for IM&T architecture
- Procure, build & roll-out IM&T
- Hand-over to support
- Commission COBIC contracts

Performance Management and Benefits Realisation

- Conduct training
- Transition preparation
- Go Live
- Performance Management and Benefits Realisation

April '13

Year 1: 2013 - 14

Q1 Q2 Q3 Q4

April '14

Year 2: 2014 - 15

Q1 Q2 Q3 Q4

April '15

Year 3: 2015 - 16

Q1 Q2 Q3 Q4

- Programme management, PMO & Benefits Realisation
- Patient & user consultation
- Stakeholder & employee communication and engagement

Driving Improved Outcomes

Enabling the Change

Clinically led, robust delivery

July 2013

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### Executive Summary

#### 1.6 High Level Implementation Plan (2013-2016)

<table>
<thead>
<tr>
<th>Programme &amp; Change Management</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
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<th>Q2</th>
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<td><strong>Programme &amp; Change Management</strong></td>
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<td><strong>4. Crisis intervention, admissions avoidance</strong></td>
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<tr>
<td>Conduct analysis of non elective admission activity</td>
<td>Local (North and South) planning and business case for 24 Hour One Team service</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
<td>Performance Management and Benefits Realisation</td>
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<tr>
<td>Agree subacute care strategy for Crisis Intervention, admissions avoidance</td>
<td>Commission rapid access medical unit at acute provider</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
<td>Performance Management and Benefits Realisation</td>
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<tr>
<td>Continue with measures to address current One Call / One Team performance and system issues</td>
<td>Commission One Team as 24hr service</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
<td>Performance Management and Benefits Realisation</td>
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<tr>
<td>Local (North and South) planning and business case and establishment of clear criteria and protocols for escalation from care homes</td>
<td>Commission integrated contact point for health and social care professionals</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
<td>Performance Management and Benefits Realisation</td>
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#### 5. Bedded Care (sub acute)

<table>
<thead>
<tr>
<th>BC 1 &amp; 2</th>
<th>BC 4</th>
<th>BC 3</th>
<th>BC 1</th>
<th>BC 2</th>
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<tr>
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<tr>
<td>Develop clear and consistent service specifications for sub acute beds (North and South)</td>
<td>Commission One Call (OC) as single control in the system for sub acute care (SSC)</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
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<tr>
<td>Enforce all ICT sites to record ICD10 codes. Use this analysis to benchmark efficiency of bed use and determine the right size community bedded services for the needs of the population</td>
<td>Commission number of beds in line with needs of population</td>
<td>Contract letting</td>
<td>Transition preparation (inc. training &amp; soft launch)</td>
<td>Go Live</td>
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</table>

#### 6. Discharge to Assess

<table>
<thead>
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<th>DA 1 &amp; 2</th>
<th>DA 3</th>
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<tr>
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<tr>
<td>Agree sub acute care strategy for Discharge to Assess</td>
<td>Commission One Call / One Team to trigger discharge process at point of admission and use early supported discharge model</td>
</tr>
</tbody>
</table>

**IM&T**
- Detailed design for IM&T architecture
- Procure, build & roll-out IM&T
- Hand-over to support

**Finance & Contracting**
- Commission COBIC contracts
- Commission COBIC contracts

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**Executive Summary**

**Between Hospital and Home | West Sussex Sub-Acute Care Strategy**

**Horsham & Mid Sussex Clinical Commissioning Group**

**Coastal West Sussex Clinical Commissioning Group**

**Crawley Clinical Commissioning Group**

July 2013