The Vision for Integrated Health and Social Care in Sutton

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| ***We all share a common purpose to put “people at the centre” enabling them to stay healthier at home for longer, by doing more to prevent ill health, supporting people to manage their own health and wellbeing and providing more services in people’s homes and communities.*** |

The following organisations are working in partnership, to achieve integrated health and social care for Sutton residents that places people and their carers at the centre.

* Sutton CCG (Clinical Commissioning Group)
* Sutton Council Adult and Children’s Services and Public Health
* Epsom & St Helier University Hospitals NHS Trust
* Royal Marsden NHS Foundation Trust
* South West London & St Georges Mental Health NHS Trust
* Sutton Healthwatch
* Local representatives of voluntary and charity organisations

# Why do we need integrated health and social care?

In 2013 the Better Care Fund was announced as part of the Government’s spending round to promote joint working between health and social care services. In preparation, the Health & Wellbeing Board adopted a Joint Strategy for Health and Social Care in Sutton which described how Sutton CCG and Sutton Council would work together to ‘enable people to maintain their independence and health in the community’.

Through developing the Joint Strategy and the submission for the Better Care Fund, partners have identified the following key areas that require more effective integration of health and social care services:

# Key areas of change

We acknowledge that we need to continue to deliver high quality services that people in Sutton expect, particularly where people prefer to receive these services in or closer to home. However, we also need to acknowledge that as in many other parts of the country, we are facing an increase in demand for health and social care services which put pressure on finances across the whole system. Therefore we will:

* Provide effective information and support that empowers and enables people to take responsibility for their health and wellbeing.
* Ensure that people experience care that is focused on their needs and supports them to achieve their outcomes, minimising duplication and delays.
* To ensure that support is given in the right way, at the right time, the right place and by the right person.
* Ensure that people with long-term conditions are supported with a co-ordinated approach to their care, to minimise duplication and “falling through the gaps” in our services.
* Ensure that views of patients, service users, staff and their representatives are taken into account in decision making wherever possible.
* Where appropriate, prevent or reduce the need for some services, by developing strong communities that can support those who are more vulnerable.
* Reduce the number of people attending accident and emergency, going into hospital or nursing / residential care when they could be supported in more appropriate and cost effective community environments.

# How will we achieve integrated health and social care?

Specifically,we will work together to achieve the following changes to our services over the next five years that will contribute to reducing or preventing hospital admissions and residential care placements, particularly for people identified at risk such as older people or those with long term conditions:

* Support communities and individuals to look after their own health and wellbeing.
* Develop community networks to work collaboratively through integrated services.
* Expand the capacity of reablement and rehabilitation services to support residents in the community.
* Re-tendering community services to enhance the impact of integrated working through revised service specifications that support this approach.
* Develop cross sector working that targets intervention and support to those most at risk of admissions to hospital and residential care.
* While continuing to focus on people with multiple long term conditions, we will work to ensure that we maintain and strengthen equality of access to services for people with a wide and diverse range of needs.
* Where appropriate, realilgn resources across health and social to ensure that we have the capacity to match changing demands.
* Align Mental Health, in particular the work around dementia and the procurement of the Primary Care Mental Health Care model will enhance integration.
* Plan and develop a community workforce in collaboration with providers which can deliver a ‘whole community’ service model, and move moreprofessionals from acute settings into the community.

To achieve our vision it is important to acknowledge that, not only does it require the design of new approaches and systems, but also a change in culture and behaviour to embed any changes. In particular we feel that it is important to:

* Promote and support a collaborative approach by ensuring that we have a common vision of coordinating care to enable people to experience integrated care, designed around their needs, in the most suitable setting.
* Look for opportunities where we can bring together existing services in primary, community, social and acute care into one overall approach thus creating minimal disruption to the service user and staff.
* Support all relevant professionals to reduce the barriers to working together by spending time putting ourselves in the other person’s shoes, respecting each others’ contribution and finding ways of working that avoid duplication.
* Acknowledge that the journey towards effective integrated services needs thoughtful planning and execution if it is to work.

If you would like more information or have any questions or comments, please contact David Jobbins, Better Care Fund Programme Manager on [david.jobbins@sutton.gov.uk](mailto:david.jobbins@sutton.gov.uk) or [davidjobbins@nhs.net](mailto:davidjobbins@nhs.net) .