West Sussex Health and Wellbeing Board

Better Care Fund Narrative Plan 2021/22

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1 Stakeholder Engagement

1.1 The draft West Sussex Better Care Fund Plan 2021-22 was presented to the West Sussex Health and Wellbeing Board meeting of 7th October 2021. The following bodies were represented:

West Sussex County Council
NHS West Sussex Clinical Commissioning Group
Arun District Council
Crawley Borough Council
Adur and Worthing Councils
University Hospitals Sussex NHS Foundation Trust
Surrey & Sussex Healthcare Trust
Sussex Partnership NHS Foundation Trust
Sussex Community NHS Foundation Trust
West Sussex Healthwatch
Voluntary Sector - Age UK, West Sussex
Voluntary Sector - Community Works

1.2 HWB Members were supportive of the draft plan and agreed that a Chair's action could be undertaken to approve the finalised planning submission.

1.3 Prior to final sign-off by the HWB Chair, the West Sussex Better Care Fund Plan 2021-22 went through the formal internal governance pathways of both West Sussex County Council and West Sussex Clinical Commissioning Group.

1.4 In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with our providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with NHS providers, private sector providers, VCS providers, and housing authorities.

1.5 Joint working is strengthened by the emerging governance and oversight structure for the West Sussex Partnership, including the West Sussex Health and Care Partnership Executive, which has a key strategic relationship with the West Sussex Health and Wellbeing Board, to deliver the health and care objectives as set out in the Joint Health and Wellbeing Strategy and is accountable to the Sussex ICS Health and Care Partnership Executive. Other forums, such as the Planning Oversight Group also bring together the stakeholders of the partnership.

2 Executive Summary

West Sussex Better Care Fund 2021-22

2.1 For 2021/22, we reviewed BCF schemes against current priorities and risks, and with regard to their alignment with priorities funded outside of the BCF including under the Hospital Discharge Policy.

2.2 Given the focus on recovery and the lateness of the BCF planning cycle, all schemes funded for the previous year are retained. However, the uplift of the CCG Minimum Contribution, has allowed the following schemes to be brought into the BCF plan:

Scheme 9 – Stroke Recovery Service: This scheme provides Stroke Recovery Support services to meet national standards and support the ambitions of the NHS Long Term Plan in respect of stroke. It also includes a Six-Month Review service offering a comprehensive, person-centred six-month review to all stroke survivors. The scheme is expanded for 2021/22 to include the service in the former Coastal West Sussex are in addition to that in the north of the county.

Scheme 10 – Combined Placement and Sourcing Team (CCG funding contribution): The Combined Placement and Sourcing Team (CPST) forms a single point of referral, triage and tracking teams for all patients leaving hospital on pathways 1 (home with care), 2 (short term bed-based reablement) -3 (complex bed-based placement) for Health and Social Care. This is accessed through the 'IDT/Discharge Hub' at each acute hospital. CPST also supports community referrals and will act as the central referral point for the wider Community Response and Reablement service supporting both discharge and admissions avoidance.

Scheme 11 – Community EOL Admission Avoidance: This scheme supports a demonstrable increase in the numbers of patients at the end of life who require an urgent community response when the patient's wish is to remain at home, to ensure a timely and personalised holistic approach to prevent avoidable admissions. Initiated following criteria assessment, it supports an up to a 48-hour package of care provided by the hospices Multi-Disciplinary Team (includes nurses, allied health professionals, advanced nurse practitioners and access to specialist medical advice and support) tailored to the situation. The scheme provides additional funding to the hospices for activity and support of patients above their core bed capacity/ baseline services. It also contributes to keeping hospices as part of the wider strategic system.

Income

Disabled Facilities Grant:	£9,414,970
Improved Better Care Fund:	£20,006.674
Additional LA Contribution:	£1,922,100
CCG Minimum Contribution:	£63,918,903
	£95,262,647

Expenditure

Committed Funding Scheme	Scheme Number	West Sussex CCG	West Sussex County Council	Committed Funding
Disabled Facilities Grant	1	–	£9,414,970	£9,414,970
Maintaining (Protecting) Social Care	2	£17,707,984	–	£17,707,984
IBCF: Meeting adult social care needs	3a	–	£5,170,674	£5,170,674
IBCF: Reducing pressure on the NHS, including supporting more people to be discharged from hospital when ready	3b	–	£8,134,000	£8,134,000
IBCF: Ensuring that the local social care provider market is supported	3c	–	£3,399,000	£3,399,000
Winter Pressures Grant	3d	–	£3,303,000	£3,303,000
Proactive Care	4	£7,165.104	–	£7,165,104
Communities of Practice	5	£4,304,099	–	£4,304,099
Better Care Fund Programme Support	6	£234,313	–	£234,313
Responsive Services	7	£17,812,048	–	£17,812,048
Social Prescribing	8	£502,600	–	£502,600
Stroke Recovery Service	9	£263,342	–	£263,342
Combined Placement and Sourcing Team (CCG contribution)	10	£454,595	–	£454,595
Community EOL Admission Avoidance	11	£420,000	–	£420,000
Care Act Initiatives	12	£2,168,200	–	£2,168,200
Carers Services	13	£1,946,000	£1,922,100	£3,868,100
Technology Enabled Care	14	£878,600	–	£878,600
Community Equipment	15a	£4,186,900	–	£4,186,900
Community Equipment (Health)	15b	£5,860,959	–	£5,860,959
Funding Reserve	16	£14,159	–	£14,159
		£63,918,903	**£31,343,744**	**£95,262,647**

Notes:

1. This plan meets the minimum spend requirements of £26,729,184 for social care, and £18,163,940 for CCG-commissioned out of hospital services.
2. Funding is allocated for the implementation of Care Act duties (Scheme 12), carer-specific support (Scheme 13), and Reablement (Schemes 2 and 7).
3. In partnership with the CCG, the County Council has prepared a Winter Plan. This involves using part of the Winter Pressures Grant to procure additional domiciliary care capacity to enable flow through the system. In turn that supplements the investment which is being funded in hospital discharge services. These ensure that people who are medically fit for discharge from hospital and do not require 24-hour care are supported to return home.

Metrics

Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population:

Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups admission to residential or nursing care homes can improve their situation.

	19-20 Plan	**19-20 Actual**	**20-21 Actual**	**21-22 Plan**
Annual Rate:	595	536	524	595
Numerator:	1189	1066	1054	1223
Denominator:	199948	198783	200968	205425

Numerator: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital.

Denominator: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.

Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services:

Rationale: There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Plan:

	19-20 Plan	**19-20 Actual**	**21-22 Plan**
Annual:	88.2%	68.2%	78.3%
Numerator:	268	191	224
Denominator:	304	280	286

Numerator: Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator.

Denominator: Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December.

Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions:

Rationale: This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The numerator is given by the number of finished and unfinished admission episodes, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. **Plan:**

	20-21 Actual (Estimated)	**21-22 Plan**
Unplanned hospitalisations for chronic ambulatory care sensitive conditions	575.9	670.4

Numerator: Hospital Episode Statistics (HES) admitted patient care (APC), provided by NHS Digital – National Statistics Final annual and quarterly HES data are usually released in the November following the financial year-end.

Denominator: Mid-year population estimates for England published by the Office for National Statistics (ONS) annually – National Statistics. Available in June following end of reporting year.

Metric 4a: Discharge Indicator Set: Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days:

Rationale: This is an important marker of the effective joint working of local partners and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Plan:

	21-22 Q3 Plan	21-22 Q4 Plan
Proportion of inpatients resident for 14 days or more	11.0%	11.7%
Proportion of inpatients resident for 21 days or more	5.9%	6.3%

Numerator: The proportion of hospital patients whose stay is 14 and 21 days or longer.

Denominator: All completed hospital spells recorded in SUS – calculation on monthly total.

Metric 4b: Discharge Indicator Set: Improving the proportion of people discharged home using data on discharge to their usual place of residence:

Rationale: There is evidence that recovery and independence for people who have been admitted to hospital are improved if they are discharged to their own home.
Plan:

	21-22 Plan
Percentage of people resident in the HWB who discharged from acute hospital to their normal place of residence:	88.0%

Numerator: The number of discharges that are to a person's usual place of residence.

Denominator: All completed hospital spells recorded in SUS – calculation on monthly total.

3 Governance

3.1 Our West Sussex Health and Care Partnership Executive (HCPE) has a key strategic relationship with the West Sussex Health and Wellbeing Board, to deliver the health and care objectives as set out in the Joint Health and Wellbeing Strategy and is accountable to the Sussex ICS Health and Care Partnership Executive.

3.2 The West Sussex Health and Wellbeing Board meets regularly as a statutory committee of the County Council. It performs a system oversight and accountability role. We will ensure that as a system, our governance enables us to effectively plan and implement together and improve performance and quality, including learning from system related incidents. It will enable us to put in place actions that can support improvements to patient pathways, patient experience and streamlines the way that services work.

3.3 The West Sussex Health and Wellbeing Board retain responsibility for governance and oversight of the Better Care Fund and receive quarterly monitoring reports. However, authority for ongoing oversight is delegated to the Joint Commissioning Strategy Group which meets monthly. The core responsibilities of the Joint Commissioning Strategy Group in relation to the Better Care Fund are in the section 75 Agreement.

Overall Approach to Integration

3.4 The West Sussex Health and Care Partnership was established in 2020 as an alliance of organisations responsible for integrating care around our local population, improving health and care outcomes and addressing health inequalities.

3.5 Our joint priorities for 2021-22 support both the West Sussex Health and Wellbeing Board vision, and the Sussex-wide Integrated Care System goals:

- People live for longer in good health.
- The gap in healthy life expectancy between people living in the most and least disadvantaged communities will be reduced.
- People's experiences of using services will be better and our staff feel supported and work in a way that makes the most of their dedication, skills and professionalism.
- The cost of health and care will be affordable and sustainable in the long term.

3.6 Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of collective public funding in West Sussex. By developing a joint West Sussex health and care plan and having a clear place-based focus, we will ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of our local population.

3.7 The COVID-19 pandemic accelerated new ways of working in a more integrated and joined up way to meet the significant challenges to restoring services, not only in hospitals, but also in social care, primary care, mental health and community-based services. This enabled new models of delivery that required a collaborative response, flexed resources including workforce to meet system wide pressures and provided significant learning to reshape a stronger and sustainable future.

3.8 We have opportunities to further develop how our services work together to streamline pathways for patients, improve experience and create more integrated approaches. Through integrated services we will remove the unnecessary barriers between our services that are all working to support the same local people and create more sustainable models of care.

3.9 We are exploring the options to most effectively commission and contract within an integrated Health and Social Care model. The identification of the ideal commissioning mechanisms and associated procurement mechanisms will support and enable future collaboration, commissioning, and integration decisions.

3.10 There are times when integration of services will be required at a larger planning footprint, across West Sussex, rather than at a local community (PCN) or area (LCN) level. Providing services at this level can ensure best use of financial and staffing resource; ensuring the service is sustainable and flexible enough to meet differing levels of demand at different time of the day or year. Similarly, service integration at a Sussex-wide level is beneficial when numbers of patients requiring services are even smaller and require specialist input and a consistent model of delivery meeting quality standards of delivery.

3.11 Our aim is to treat and manage conditions largely in the community, providing a more personalised approach for patients, proactively addressing issues as they arise, reducing the need for extended hospital stays and freeing up capacity within secondary care. We have a range of integrated models and services in development, and we need to ensure we continue to develop this against a consistent approach and set of principles that allow our models to meet the need our communities.

3.12 We are learning from the Covid-19 pandemic which has had a significant impact on how patients use services and how health and care professionals work. It has further demonstrated the need to re-think how we provide service differently to achieve people's aspirations. We will therefore continue to design and develop services to:

- Enhance service offerings based on local community need, at and closer to home by developing multi-disciplinary place-based models for integrated care.
- Enable patients to stay at home supported by personalised care plans agreed in advance, and appropriate 'wrap around' services.
- Deliver a fully digitally enabled service model.
- Maximise opportunities for remote consultation by telephone and video

3.13 Our integrated model of care will address:

- Service fragmentation across primary, community including voluntary sector, social care and acute providers for physical and mental wellbeing.

- Overcome pathway inconsistencies whilst recognising local evidence-based nuances requiring specific needs.
- Service standardisation so that patients understand what is available and how to access them.

3.14 Our plan is underpinned by ensuring health services work better together but also that health and social care work better together. Our current plans demonstrate many examples of how we are strengthening our health and social care service integration and we will continue to identify and develop those opportunities.

3.15 Our health and care plans deliver not only our joint heath and care vision but also align fully with the Council's priorities to:

- Keeping people safe from vulnerable situations.
- A sustainable and prosperous economy,
- Helping people and communities to fulfil their potential.
- Making the best use of resources.

3.16 As we develop this health and care plan over the coming months, adult social care will also be developing its own plan. Health and social care partners will work together to identify further opportunities to integrate health, social care and wider local government to inform both plans going forward.

3.17 To enable people who live in West Sussex to live long, independent and fulfilled lives, Adult Services have identified three strategic objectives:

- To maximise independence in a personalised and meaningful way through early intervention and prevention approaches thereby reducing need for long term services.
- To ensure access to services will be clear and transparent with quality information and advice readily available at every step including transitioning between services.
- To work with partners to support and safeguard vulnerable adults by taking a robust, personalised approach that embodies best practice and promotes wellbeing.

3.18 These will be achieved through the following Adult Services operational objectives:

- Promoting wellbeing and resilience in people and communities across West Sussex.
- Working collaboratively with partners (e.g., the NHS, VCS) to embed strength-based approaches,
- Supporting adults most in need or at risk.
- Providing modern, safe and sustainable services across communities.
- Making the best use of resources through commissioning in an efficient, effective and economic way.
- To manage new and existing demand and maximise outcomes for West Sussex residents.

3.19 The key shared transformation priority for integrated care is:

- Primary and Community Care Integration: Crawley - We will further develop the primary and community care integration model that will enable the flexibility for services to meet the needs of its local community. Building strong links to Crawley Borough Council and the wider community asset base we will increase the availability and range of interventions that can support people to improve their health and wellbeing and improve the outcomes for the people of Crawley. Learning from Crawley Community Network will be shared with other developing Local Community Networks across West Sussex. Developing that integration at pace in Crawley, in the first instance, will enable us to improve the health and well-being of a particular deprived area and roll out learning to other areas
- Communities of Practice (COPs) – The Better Care Fund scheme, Communities of Practice (COPs) is an approach that brings together proactive care and community nursing teams aligned to Primary Care Networks where operational and geographic constraints allow. These are extended community teams, bringing together the care resources of community and mental health services, social care services and third sector organisations, focused on a registered population. They form the building block of a wider new model of care. It tests and widens new skills and roles, empowering and engaging staff to work in different ways within teams – across primary and community-based services, including increased use of pharmacists, community paramedics and working with the third sector. It empowers and supports patients and their carers, to give them the knowledge, skills and confidence to manage their own condition and providing support for the population to stay well and prevent future ill-health. This model has been developed in Crawley, Horsham and Mid Sussex and will be rolled out across other areas targeting services for different groups of patients.
- Health in Housing Memorandum of Understanding (MOU) – Build on our Health in Housing Memorandum of Understanding (MOU) for organisations in West Sussex to co-develop and make a collective commitment towards the use of housing to improve the long-term health and wellbeing of our communities has been developed and agreed. Our priorities have been set around: Extra Care Housing, Supported Accommodation, enabling people to remain in their homes longer
- Develop our integration ambition to set out how our current integrated models come together and to develop a single vision. We will build on the principles of co-production with the voluntary sector which were developed in 2019. We will develop a roadmap for how our integration model will grow, integrating more and more services over time. The benefits sought for our community include:
    - The person is treated not a condition.
    - Better joined-up, seamless care, with less handoffs.
    - Better anticipatory and preventative care.
    - Tailored services that meet the need of the community.

3.20 For 2021/22, the core BCF-funded services are largely unchanged from the previous year although they provide a building block for our integration ambitions and will develop further as part of our transformation journey.

4 Supporting Discharge (National Condition 4)

4.1 Our priorities and supporting plans for discharge have been developed and agreed under the place-based West Sussex Health and Care Partnership Plan 2021/22. The Partnership allows for shared decision-making and responsibility, whilst sustaining the sovereignty and statutory accountability of each individual organisation. It brings together local leaders from primary care, acute providers, our community providers, our mental health provider, West Sussex County Council, and NHS West Sussex Clinical Commissioning Group.

4.2 Building on lessons learned from the Covid-19 pandemic, we will transform the models of admission avoidance and hospital discharge, integrating services across health and social care, to provide the most effective preventative and reablement support.

4.3 As part of our pandemic response, care hotels were established as a new destination on discharge from acute care as a short-term measure during the second surge, to support reducing the length of stay for people in hospital and we introduced a new way of working with some of our Extra Care providers to support discharge.

4.4 We created a Combined Placement and Sourcing Team, part-funded by the Better Care Fund, under our Community Response and Reablement programme to develop a consistent approach to co-ordinating and accessing the care market of the wider health and social care community, ensuring patients can be discharged in a timelier way.

4.5 For Community, our Key Transformational Priorities for Community for 2021-22 and 2022-23 include:

- Community Response and Reablement – We are transforming the models of admission avoidance and hospital discharge, integrating services across health and social care, to provide the most effective preventative and reablement support, including:
- To continue to test the Discharge to assess model including a single Discharge Hub across all acute flows under the temporary national hospital discharge programme.
- As the national Hospital Discharge Programme is temporary, we will need to establish a means to continue funding this new model of discharge more sustainably in order to make it a long-term commitment.

4.6 For Community, our Priorities and Deliverables for Community for 2021/22 include:

- Combined Placement and Sourcing Team – develop a consistent approach to co-ordinating and accessing the care market of the wider health and social care community, ensuring patients can be discharged in a timelier way
    - To continue testing the model and find establish a means to sustainably embed this, ensuring lessons learnt are addressed or supported in any future model once temporary national funding ends.

4.7 Within Urgent Care, Significant focus has been given to supporting patient flow and reducing pressure on urgent care services through focusing on people in our hospitals who are medically ready for discharge after an acute admission. We have set ourselves a shared ambition to minimise the length of time a person is waiting for their supported discharge from hospital once they are medically ready

to leave. The ambition is to reduce the time that patients spend waiting with a focus on working collaboratively to improve system and processes to reduce delays.

4.8 Our Priorities and Deliverables for Urgent Care for 2021/22 include:

- Continue to implement the Medically Ready for Discharge Action Plan which sets out a number of improvement opportunities across the system, including an ambition to further develop the Discharge to Assess (D2A) model and discharge processes in a sustainable way, including discussions in relation to ensuring there is sufficient and responsive community capacity.

4.9 In addition to Combined Placement and Sourcing Team, the Better Care Fund supports a wide range of activity supporting safe, timely and effective discharge. This includes reablement services, Technology Enabled Care, Community Equipment, core social care services, and the Improved Better Care Fund.

4.10 Home First (HF) continues to be a focus for the West Place System and ongoing review and development will ensure as many patients as possible are discharged home from a stay in an acute hospital or community bedded setting. HF underpins our delivery of a Discharge to Assess (D2A) approach, enabling patients to come home as soon as they are medically ready, with support wrapped around them by joint Health and Social Care service. The HF service will be in place for up to 10 days, delivering therapeutic and care interventions to allow full, appropriate assessments to take place in someone's own home.

4.11 Over the 2 years the HF service has been in place, we have seen the number of patients returning home increase and the number being discharged into a community bed decreasing. We are aiming to build on this trend and continue to reduce the number of days a patient is waiting to go home from an acute setting once they are medically ready to. The key contracts commissioned for HF, which include block care hours and the core Responsive Services contract, are being reviewed and work being undertaken with the market to increase the capacity available.

4.12 The key challenges come from the market, being able to supply enough domiciliary carers, therapists and care assistants to meet the demand coming through. To better understand these gaps and gain clarity on the financial requirements, a large piece of 'demand and capacity' work is being undertaken across the clinical pathways, working with all stakeholders to ensure HF services are adequately resourced. In addition, a suite of Key Performance Indicators and Return On Investment are being developed to better demonstrate the longer-term benefits of the HF pathways.

4.13 As noted for the Expenditure Plan, the West Sussex partners have prepared a Winter Plan. This involves using part of the Winter Pressures Grant to procure additional domiciliary care capacity to enable flow through the system. In turn that supplements the investment which is being funded in hospital discharge services. These ensure that people who are medically fit for discharge from hospital and do not require 24-hour care are supported to return home.

5 Disabled Facilities Grant and Wider Services

5.1 There is a local agreement, encapsulated in a formal partnership agreement, which sets out how the upper-tier local authority and 7 West Sussex district and borough councils will work together. This allows funding to be top sliced to fund

the DFG project and the two countywide services, Minor Adaptations & Repairs, and Deep Clean and Clearing.

5.2 The project governance includes a multi-agency Working Group and Steering Group, overseen by the Chief Executives Board, who propose funding after the top slice is made. An annual update report is also taken to the West Sussex Leaders and Chief Executives Group.

5.3 A Memorandum of Understanding (MoU) which sets out the objective of joint working across the county. The overarching goal of the MoU is for the county to become an exemplar of good practice in joint working between Health, Housing and Social Care to deliver the best outcomes possible for the vulnerable households reliant on these services in West Sussex. Under this MoU we will:

- Build on Strengths
- Take a whole systems approach
- Design, develop and deliver together
- Be focused, efficient and valued
- Be outcome based

5.4 This opportunity has been born from the formation of the West Sussex Health and Care Partnership Executive, which represents senior leaders from health and care working together to deliver change and develop partnership arrangements. The West Sussex Health and Care Partnership has given its unanimous support to the proposal that local NHS partners work together with all the West Sussex Local Authorities, as well as a wider stakeholder group, to develop a health in housing memorandum of understanding.

5.5 As a member the West Sussex Health and Care Partnership Executive, West Sussex CCG is responsible for ensuring health care resources are best allocated to meet the population health needs of West Sussex, in an equitable way that includes patient and public involvement. The CCG recognises the important role of housing in long term health outcomes and as a preventative factor in avoiding or delaying deterioration of health and escalation of care. The CCG will work with local health and care partners to provide place-based leadership, expertise and system coordination in the delivery of health services across communities, including how support is provided to people in their homes.

5.6 The countywide West Sussex Disabled Facilities Grants Policy 2020 – 2024 covers all 8 authorities in West Sussex. It brought in the ability to implement practical examples of the joint working with health and social care and a range of discretionary grants for example hospital discharge grants. These have made a real difference to the speed at which residents can return home after hospital, discharge to assess beds and respite placements. This grant can also be used to prevent hospital admissions.

5.7 Joint visits to residents' homes are regularly undertaken with housing health and social care teams and this is particularly vital in complex cases. For school age children at specialist schools this also includes the school OTs, physios and medical staff.

5.8 The WSCC Independent Living Teams and the Local Authority Grants teams/Home Improvement Agency (HIA) undertake regular joint training and update sessions with colleagues from hospital discharge units and hospital OT teams alongside specialist contractors and suppliers.

5.9 The roll out of the Safe and Habitable Homes approach focuses on a resident's home environment, covering a wide range of factors for example fire risk, falls risk, substance dependency and misuse, lack of heating, hot water, safe electrics and gas, property condition and repairs, medical and health needs, access and physical adaption needs, self-neglect and hoarding. The home assessment template and supporting process enables assessment of a household and their home environment, giving the option of a 'team around the person approach', and detailed guidance on bringing about change and resolution. Regular Safe and Habitable Homes Forums are held, covering the north and south of the county, where a panel drawn from housing, health, social care, and fire services are able to advise those professionals bringing cases.

5.10 The local authority housing standards, and grants teams, and the HIA offer a holistic approach to residents advising them on moving to 'right size' or for a property more suitable for adaptation. The county wide policy includes a Moving Home Grant which provides funding to help residents to move to meet their needs more easily.

5.11 This advice also includes help and advice with property condition and repairs issues, landlord and tenant responsibilities for rented homes, pest control and pets. Residents can be signposted to benefit services and agencies such as the Citizens Advice Bureau. In addition, HIA signpost for a wide range of enquiries which never get as far as a case.

6 Equality and Health Inequalities

6.1 West Sussex is one of the least deprived areas in the country, ranked 129th of 151 upper tier authorities (1 being most deprived, 151 being least deprived), with a relatively high life expectancy, low unemployment, low child poverty rates and an outstanding natural environment and rich cultural assets. However, this masks the health inequalities within the county, with some areas ranking amongst the 10% poorest neighbourhoods in England. We know that the environment in which people are born, grow, live, work and age have a profound effect on the quality of their health and wellbeing. Many of the strongest predictors of health and wellbeing, such as social, economic and environmental factors, fall outside the healthcare setting. These wider determinants of health have a significant impact and the poorest and most deprived are more likely to be in poor health, have lower life expectancy and more likely to have a long-term health condition or disability.

6.2 Many health inequalities exist within the county. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as tobacco control, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on local epidemiology and evidence of what works. We will make care more personalised so that people can access health and care services that are more tailored to their needs, make sense to them and focus on what really matters in their lives.

6.3 The increased negative impact and risk of the COVID-19 infection on the BAME communities is still being understood and assessed by government, health services and academics. However, the Marmot Review1 highlighted that people living in deprived areas and those from a BAME background were not only more likely to have underlying health conditions because of their disadvantaged

backgrounds, but they were also more likely to have shorter life expectancy as a result of their socioeconomic status, the social determinants of health. Research and activity is currently underway across Sussex, focusing upon areas such as Crawley where there is a larger BAME population, to better understand how experience of accessing health services, along with life circumstance and how health promoting activities are disseminated play a part in the poorer health outcomes for BAME populations.

6.4 The diversity across West Sussex means that a model of prevention and reducing health inequalities that is based upon District and Borough geographies can be more effective in targeting local priorities than taking a West Sussex wide uniform approach. A strong partnership approach provides the best opportunity to tackle inequalities and develop effective preventative approaches. The experience of working together during the Covid19 response to tackle a common goal has highlighted how effective this can be. At the same time the unequal impact of the virus upon disadvantaged groups within the population, most notably BAME communities, has renewed ambition to tackle inequalities. The development of Local Community Networks builds on previous local partnership models that proved the concept of benefit of primary care working more closely with local government and voluntary sector colleagues within District and Boroughs, as well as local communities themselves. Current examples of priority areas of joint activity include inequalities in cancer screening and outcomes; young people's mental health – supporting parents and families; and a multi-agency approach to CVD in a small defined deprived housing estate. It is expected that these early examples will provide the way for broader sets of priorities for local community networks.

6.5 Our place-based plan, developed since the last Better Care Fund plan, recognises that the unequal impact of Covid-19 on our community has highlighted the need for post Covid recovery activity that improves the wider determinants of health, where:

- Disproportionate economic impacts on women, black, Asian, and minority ethnic (BAME), and disabled people.
- Disproportionate impacts of the virtual classroom.
- Disproportionate impacts upon low-income communities.
- Barriers to accessing support and following guidelines due to lack of trust and confidence in statutory service provision and information, especially for some BAME communities including migrants.
- Digital exclusion, including from digital health appointments, particularly for older people and those in poverty, from across all communities, but especially those for whom English is not a first language.
- Specific issues around isolation and impact on mental wellbeing and increased frailty.
- Heightened health concerns for BAME, LGBTQ, and disabled people.
- The impact upon the mental health of young people.
- The safety of women during the lockdown period, particularly relating to domestic abuse and housing provision.

- The reduced uptake of Covid19 vaccinations by some ethnic minority and some migrant communities and potential lack of trust in Test and Trace systems.

6.6 We will ensure coordinated actions are driven forward to address the wider determinants of health to 'build back fairer' and mitigate against further widening. Therefore, we will work with local communities to target provision where it is needed, based on the local epidemiology and evidence of what works.

6.7 Our vision and goals describe our shared system vision to tackle the gaps in healthy life expectancy between people living in the most and least disadvantaged communities.

6.8 We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health relating to CVD, respiratory and cancer. We will utilise approaches such as smoking, cancer screening and health checks and work together with key stakeholders across the area to target our activity and resources where it is needed most based on local epidemiology and evidence of what works.

6.9 We know that addressing those inequalities is often and best done at place level – the closest point to our communities. Across West Sussex, local communities, and primary care networks, we will further develop our working with communities to co-design and deliver local targeted actions. Our approach to tackling health inequalities will be:

- To plan and deliver actions to address health inequalities with our partners across Sussex, at place and in neighbourhoods through a combination of civic-level interventions, service-based interventions, and community-centred interventions.
- To change the way we commission and provide service, with a renewed focus on reducing health inequalities at the centre of everything we do, including:
    - Proportionally targeting our resource to match the needs of individuals and communities to reduce the gap in live expectancy and to increase the quality of life, ensuring resources and delivery are in line with need, which may result for example in increasing resources for providers in more deprived areas in comparison to less deprived areas.
    - Having robust mechanisms to reach, hear from and better understand people and communities' experiences.
    - Ensuring services are informed by both peoples' and communities' needs and assets.
    - Connecting out knowledge of local health inequalities with front line service delivery.
    - Taking action for people from pre-conception to after-death.
- To recognise that delivering action to reduce health inequalities takes time, which is often in conflict with our funding arrangement and that we must continue to strengthen relationships with local authorities, the voluntary sector, local people and communities to address this.
- To acknowledge that the need to act is urgent and the moral, social, economic and physical case for change is stronger than ever. By accepting

this, commit to act swiftly and ensure we take meaningful action to address inequality as a core element of all aspects of our work.

6.10 Our key shared priorities for addressing health inequalities are:

- Smoking in outlying areas – We will build on the work of the Smoking Cessation programme to understand how to best focus on the outlying areas, developing the targeted approach further. West Sussex Public Health's smoking cessation programme supports all residents for treatment of tobacco dependency. It is complemented by the West Sussex tobacco control plan (2019 – 2022), which addresses tobacco control across the West Sussex area.
- Cancer access – We will develop a tailored plan to tackle late presentation by understanding the reasons and barriers to accessing early diagnosis.
- Physical health checks and for people living with serious mental illness or learning disabilities - We will develop further our primary care communications, voluntary and community sector support, our local commissioned services and a clinically led training and education programme in primary care. We will achieve maintain the 60% national standard by December 2022 of adults on the SMI register and we will increase up to achieve and maintain 75% on adults on the LD register.

6.11 Working as part of the Sussex ICS programme, the delivery priorities for 2021/21 are:

- We will establish a Health Inequalities Steering Group in West Sussex Place, which will work within the ICS Health Inequalities Programme to oversee delivery of the BAME recommendations as part of wider health inequality objectives.
- As part of the wider Sussex Local Commissioned Service review, we will ensure that any unwarranted variation that currently exists across West Sussex is addressed and known areas of inequalities, demonstrated though the intelligence produced by our Population Health management programme, is a key area of focus for these contracts.
- Population Health Management activity in Crawley will be further developed
- West Sussex wide information, learning, engagement, reporting and governance structures will be finalised and agreed with partners in order to produce a locally sensitive but countywide approach to tackle health inequalities. Local project outcomes will be fed into a countywide outcomes matrix.
- The work addressing inequalities amongst BAME communities will expand across West Sussex, building on the existing work in more densely BAME populated areas to ensure that further inequality is not created.
- Spread and scale the 6 core components of personalised care, namely Shared Decision Making, choice, Personalised Care and Support Planning, Supported Self-Management, Personalised Care and Community-Based Support and Personal Health Budgets.
- Further work in relation to Social Prescribing will include work to ensure that the various services are strategically supported to promote equity of access. Work will also include finalisation of a West Sussex wide service model and accompanying work over the next 18 months to align to the local neighbourhood community network development.

- Continue to engage with key communities and work to tackle known inequality in Covid19 vaccine uptake by, working with BAME communities and Faith groups to address vaccine hesitancy.

6.12 The benefits sought for our community include:

- Increased quality of life.
- Improved health outcomes.
- Live longer for many people.
- Earlier detection of health conditions that can then be treated or managed more effectively.

6.13 As we develop at place, services funded by the Better Care Fund will further align with our priorities. For example, we will undertake further work in relation to Social Prescribing to ensure that the various services are strategically supported to promote equity of access.

6.14 The West Sussex BCF schemes are subject to the requirements of the partner organisations in respect of Equality Impact Assessments currently at scheme-level. As we develop at place into 2022/23 and beyond, any review and restructuring of our BCF programme will require refreshed Equality Impact Assessments.

6.15 We will utilise the data available on age and ethnicity within the Discharge Indicator Set to analyse and report on inequality of outcomes, and further explore this in relation to the other Better Care Fund national metrics, including the interface with our developing key performance indicators for addressing inequalities.

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