West Sussex Health and Wellbeing Board

Appendix 1 - Better Care Fund Narrative Plan 2022-23

1 Stakeholder Engagement

Due to this year's planning period falling between meetings, the West Sussex Better Care Fund Plan 2022-23 will be presented to the full West Sussex Health and Wellbeing Board meeting of 3rd November 2022. The following bodies will be represented:

West Sussex County Council
NHS Sussex
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

Prior to this, the West Sussex Better Care Fund Plan 2021-22 went through the formal internal governance pathways of both West Sussex County Council and NHS Sussex Integrated Care Board.

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. Other forums, such as the fortnightly Planning Oversight Group also bring together a wide range of system partners and stakeholders.

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 Health and Care Assembly (ICS).

2 Executive Summary

West Sussex Better Care Fund 2022-23

For 2022/23, we reviewed BCF schemes against current priorities and their alignment with BCF priorities. Given the lateness of the BCF planning cycle, inflationary pressures, a fragile care market, and workforce challenges, all schemes funded for the previous year are retained and no new schemes have been added.

Income

Disabled Facilities Grant:	£9,414,970
Improved Better Care Fund:	£20,612,666
Additional LA Contribution:	£1,922,100
NHS Minimum Contribution:	
NHS Sussex IBC	£67,016,275
NHS Surrey Heartlands IBC	£520,438
	£99,486,449

The area covered by NHS Sussex ICB is co-terminus with the administrative boundaries of the 3 local authorities with the exception four Lower Layer Super Output Areas in West Sussex which are currently within NHS Surrey Heartlands ICB. This is a repeat of the situation applying in 2015/16, the first year of the Better Care Fund, when these areas were within the boundary of Guildford and Waverley Clinical Commissioning Group for that year only, and the corresponding funding was paid by them to Horsham and Mid Sussex Clinical Commissioning Group, allowing the West Sussex Better Care Fund programme to operate as co-terminus.

Expenditure

Committed Funding Scheme	Scheme Number	NHS Sussex	West Sussex County Council	Committed Funding
Disabled Facilities Grant	1	–	£9,414,970	£9,414,970
Maintaining (Protecting) Social Care	2	£18,356,656	–	£18,356,656
IBCF: meeting adult social care needs	3a	–	£10,809,666	£10,809,666
IBCF: reducing pressures on the NHS, including seasonal winter pressures	3b	–	£2,900,000	£2,900,000
IBCF: supporting more people to be discharged from hospital when they are ready	3c	–	£1,706,000	£1,706,000
IBCF: ensuring that the social care provider market is supported	3d	–	£5,197,000	£5,197,000
Proactive Care	4	£7,566,093	–	£7,566,093
Communities of Practice	5	£4,544,295	–	£4,544,295
Better Care Fund Programme Support	6	£320,660	–	£320,660
Responsive Services	7	£18,136,288	–	£18,136,288
Social Prescribing	8	£486,171	–	£486,171
Stroke Recovery Service	9	£263,651	–	£263,651
Combined Placement and Sourcing Team (CCG contribution)	10	£814,595	–	£814,595
Community EOL Admission Avoidance	11	£888,782	–	£888,782
Care Act Initiatives	12	£2,185,600	–	£2,185,600
Carers Services	13	£2,261,800	£1,922,100	£4,183,900
Technology Enabled Care	14	£1,110,900	–	£1,110,900
Community Equipment	15a	£4,485,600	–	£4,485,600
Community Equipment (Health)	15b	£6,115,622	–	£6,115,622
		£67,536,713	**£31,949,736**	**£99,486,449**

Notes:

1. This plan meets the minimum spend requirements of £28,242,056 for social care, and £19,192,019 for NHS-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).

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 - Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.

		2020-21 Actual	2021-22 Plan	2021-22 Estimated	2022-23 Plan
Long-term support needs 65+ met by admission to residential and nursing care homes, per 100,000 population:	Annual Rate:	524.5	595.4	462.9	595.8
	Numerator:	1,054	1,223	951	1,244
	Denominator:	299,968	205,425	205,425	208,802
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). ***Denominator:*** Size of the older people population in area (aged 65 and over).					

Rational:

Performance in 2021-22 remains unrepresentative of normal patterns of admission following the impacts of Covid-19 although this is not a marked as for the previous year. and into the current year has been significantly impacted by the effects of Covid-19. We have seen a significant increase in demand in all areas of adult social care, due to pent up demand. This has impacted on the numbers of new admissions to residential settings, with admissions now increasing.

We continue to work towards reducing new admissions to residential settings, where the average cost of placements is increasing due to market pressures and complexity of customer need, while increasing non-residential options. While this is showing some movement in the right direction, restoration is a priority and the setting of our target for reducing rates of admission to residential and nursing homes for people over the age of 65 is pitched to that priority.

Ambition:

For 2022-23, BCF-funded and non BCF-funded continue to support a home first approach to hospital discharge, coupled with reablement / rehabilitation support, enabling people to remain independent in their own home. Many other BCF schemes will contribute to reducing residential admissions. For example, the many services provided under Scheme 2, Maintaining (Protecting) Social Care or the targeted use of the Disabled Facilities Grant.

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

		2020-21 Actual	2021-22 Plan	2021-22 Estimated	2022-23 Plan
Proportion of older people (65+) still at home 91 days after discharge into reablement / rehabilitation services:	Annual %	68.9%	78.3	60.1%	78.4%
	Numerator:	202	224	119	228
	Denominator:	293	286	198	291

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.

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).

Rational:

Performance has fallen consistently below target over recent years. We have always interpreted the measure as per the guidance. We call the customer three times to check they are at home, but if they do not respond, we assume they are not. We believe some areas use a different system. That after the three calls, they check hospital admissions or care placements and assume the customer is at home if not in care. Hence our numbers tend to be low. ADASS feel that the 91-day measure is not fit for purpose and are looking to remove this measure and refresh ASCOF.

For 2022-23, and given the issues discussed above, and the restoration of normal services following Covid-19, we are maintaining a more realistic target seeking to improve performance, as recorded by this measure, over that of previous years.

Ambition:

West Sussex will continue to ensure there are effective out of hospital services and that people are supported in their own homes. For 2022-23, we continue looking at discharge pathways from hospital, and increasing the effectiveness of reablement. We will further develop and improve home-based health and social care services to enable people to be discharged directly to their home with the right services and support. West Sussex will continue to ensure there are effective out of hospital services and that people are supported in their own homes.

Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions - The number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency, 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.

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual
Indirectly standardised rate (ISR) of admissions per 100,000 population:	Indicator value:	169.2	153.2	166.0	134.4
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q1 Plan
	Indicator value:	141.8	127.1	138.0	119.2
Numerator: Unplanned admissions by quarter for ambulatory care sensitive conditions. Hospital Episode Statistics (HES) admitted patient care (APC). ***Denominator:*** Mid-year population estimates for 2020-21.					

Rational:

Quarterly planned figures for 2022-23 are based on the reductions identified in local data between Q1 2021-22 and Q1 2022-23 subsequently phased based on 2021-22 patterns. This local data closely matches that centrally produced. The population figures underpinning this calculation have also been uplifted marginally based on published estimates for 2022-23.

Note that the quarterly plan figures entered on the planning template are rounded as it will only accept whole numbers.

Ambition:

The pan-Sussex ambition is to maintain improvements seen since Q4 2021-22. Further improvements are anticipated through schemes targeting specific conditions (under the Ageing Well Programme), with further development of Urgent Community Response, Same Day Emergency Care, and Virtual Ward pathways, however these schemes are not now anticipated to deliver significant benefits until 2023/24.

A number of West Sussex BCF-funded schemes support admission avoidance. In particular we have well-established community-based multi-disciplinary PCN teams working closely with primary care such as Proactive Care and Communities of Practice.

Metric 4: Discharge to usual place of residence - The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence.

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual
Percentage of people, resident in the HWB area, who are discharged from acute hospital to their normal place of residence:	Quarter %:	86.2%	86.7%	86.4%	86.9%
	Numerator:	16,597	16,520	16,034	15,233
	Denominator:	19,261	19,060	18,561	17,530
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q1 Plan
	Quarter %:	87.0%	86.8%	86.2%	87.0%
	Numerator:	14,895	13,969	13,457	14,895
	Denominator:	17,114	16,102	15,609	17,114
Numerator: The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. ***Denominator:*** All completed hospital spells for people over the age of 18 – calculation on monthly total.					

Rational:

Plan for year based on extrapolation of Q1 2022-23 performance. This has been phased for the remainder of the year based on 2021-22 Activity. West Sussex, in common with the other Sussex HWB areas, has seen a reduction in overall activity levels in Q1 compared with 2021-22. This is primarily due to 'delayed discharges'. The assumption is that this trend is likely to continue through to Q3.

West Sussex figures for discharge under Pathways 0 and 1 tend to be lower than those in our neighbouring areas. There are several factors feeding into this:

We have an older and more complex population meaning that a greater proportion may require further support in a bedded setting upon discharge. Hence, the Pathway 2 offer, discharging into an interim bed for up to 6 weeks to get them home, is larger in both scope and size than that in the other Sussex HWB areas.

In addition, an area such as East Sussex may have twice as many people in care homes than we do. Therefore, it can be easier to send them back to usual place of residence. In West Sussex we keep more people in their own homes.

Ambition:

Implementation of a revised pan-Sussex model for Hospital Discharges aims to enable activity levels and 'discharges to normal place of residence' to return to Q1 levels by Q4. Whilst this ambition remains below the national average, it meets the particular circumstances of our area.

A wide range of BCF-funded services which support discharge and reducing length of stay. Examples include social workers in hospitals, Home First, Community Equipment, and Technology Enabled Care.

3 Governance

Our West Sussex Health and Care Partnership Executive (HCPE), which brings together system partners, 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.

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.

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 defined in the section 75 Agreement.

The West Sussex Place-Based Plan, drawn from the Joint Health and Care Strategy and the Sussex ICS Vision 2025 objectives, sets out aspirations to work with communities and local people in redesigning services to overcome some of the current challenges with access and take up of support, using local evidence based in population health needs and health inequality.

The West Health and Care Partnership provides the local collaborative leadership to deliver the place-based plan, as well as having local oversight of system quality and performance improvement. It brings us together around our population, rather than an organisation, to focus on delivering a common set of priorities. The 2022 Health and Social Care Act and the Government Integration white paper sets a strong expectation that Integrated Care Systems operate a 'primacy of place' principle, with the ambition to develop place collaborative arrangements into more formal delegated leadership models by April 2023.

Involving patients, residents, communities, the VCSE sector (voluntary, community and social enterprise), and the district and borough councils in the governance of collaborative decision-making structures provides an important way of strengthening local accountability, within the West Sussex place-based partnership.

4 Overall Approach to Integration

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.

Taking its lead from the Health and Wellbeing Board's Joint HWB Strategy, the West Sussex Health and Care Partnership has agreed its three priorities:

- Addressing health inequalities – We know many health inequalities exist within the county. We will prioritise the key health inequality related areas such as 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.
- Integrating models of care - 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.
- Transforming the way we do things – We will continue to improve our services where it will have the greatest impact, taking the opportunity to address health inequalities and strengthen our integrated approach. We will continually review our joint transformation priorities year on year, systematically improving our services.

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.

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.

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.

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.

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.

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.

We will 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

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.

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.

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.

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.

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.

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.

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 a PCN teams' 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.

For 2022-23, 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.

During 2022-23 we will update our West Sussex Place-based plan with:

- Updated Sussex NHS Priorities with partner interdependencies.
- Updated West Sussex shared health inequality priorities.
- Shared hospital discharge plan.

Further development will encompass:

- WSCC Corporate Plan and Directorate Business Plans with partner interdependencies
- VCSE and D&B co-production.
- Integrated commissioning aligned with place share priorities.
- Shared indicators and outcomes framework.

5 Implementing the BCF Policy Objectives (National Condition 4)

Objective 1: Enable people to stay well, safe and independent at home for longer

The West Sussex Partnership priorities, including integrating models of care, described in Section 4 of this plan will support more people remaining at home while receiving health and care services.

Our Better Care Fund PCN teams' schemes, Proactive Care and Communities of Practice as further described in Section 4 of this plan, play a key role in enabling people to remain at home and in reducing avoidable admissions. They support our population in staying well and preventing further ill health by taking a multi-disciplinary approach joining-up community, social care, and mental health teams with third sector organisations, pharmacists, community paramedics, and others.

Our Community EOL Admission Avoidance scheme supports patients at the end of life who require an urgent community response when the patient's wish is to remain at home, supporting an up to 48-hour package of care provided by the hospices MDT (includes nurses, allied health professionals, advanced nurse practitioners and access to specialist medical advice and support) tailored to the situation. Recent figures show an average of over 50 packages per week, and funding for this scheme anticipates further growth.

Our ambition to further develop our Sussex-wide Ageing Well Programme, alongside Urgent Community Response, Same Day Emergency Care, and Virtual Ward pathways will further contribute to performance against BCF national metrics in general and by reducing avoidable admissions.

Objective 2: Provide the right care in the right place at the right time

Our Partnership priorities, including integrating models of care, described in Section 4 of this plan will support people more people returning home following an episode of inpatient hospital care.

Our priority for improving discharge continues to be the Home First (HF) pathway, ensuring 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, led by Sussex Community NHS Foundation Trust and supported by social care professionals and care providers commissioned by the council, 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.

Our 'Discharge to assess with reablement' services are designed to support the regaining as much independence as possible after discharge by providing reablement in a care home in the community, with 24-hour care and support available. Social care workers, occupational therapists and care staff are on hand to assess any ongoing care and support needs and to provide assistance to enable a return to the usual place of residence wherever possible. The service plays a key role in ensuring that people who are medically ready can be discharged from hospital and importantly ensures that no long-term decisions concerning care and support needs are made in hospital.

In addition to Home First and reablement services, the Better Care Fund supports a wide range of activity supporting safe, timely and effective discharge. This includes

the Combined Placement and Sourcing Team, Technology Enabled Care, Community Equipment, and core social care services.

A Capacity and Demand template has also been completed for Intermediate care services in East Sussex as part of the BCF submission for 2022-23.

High Impact Change Model for Managing Transfers of Care

During the writing of this plan, the West Sussex Operational Executive (OPEX) reviewed the Hight Impact Change Model alongside the NHSE 100-day challenge requirement. OPEX agreed all changes/requirements remain at mature or established status and developing as work continues to improve discharge pathways following changes to the Hospital Discharge Programme (HDP).

The West Sussex priority remains the home first pathway to ensure people can return home with the support they need as soon as they are medically ready to do so. The discharge pathways work will remain under review by OPEX who will oversee any future actions required to improve HICM performance.

6 Supporting Unpaid Carers

West Sussex recognises the vital role carers play in our communities and the importance of supporting and empowering those who draw on care, unpaid carers, and their families.

The West Sussex Joint Commitment to Family and Friend Carers 2021-2026 states the main priority elements for health and social care in the support of adult carers and young carers. It lets local people, and organisations, know how our approach will be developing and is an invitation to join us in our efforts. It identifies six priority areas:

- Reduce carer isolation.
- Limit financial hardship.
- Contingency planning.
- Advance equality of access.
- Targeted support.
- Greater recognition.

  https://www.westsussex.gov.uk/media/16996/joint_carers_strategy.pdf

The budget for the commissioning of carer support services is circa £5m p.a. The contracts are for the most part with charitable sector partners.

The presence of a carer in the lives of a patient, or potential patient, is a significant strength/resilience factor that needs to be recognised and supported. Healthy carers who are supported to care well help support client/patient outcomes, independence and for people to remain in their own home.

Carers, especially those with longer term caring roles, experience health inequality compared to the non-caring population, and this has been recognised recently by West Sussex with carers being a PLUS group under Core20Plus5.

West Sussex, for a number of years, has actively reached and supported a greater number of carers. 32,000 carers in West Sussex are currently on our register. These registrations are held with Carer Support West Sussex (CSWS) a commissioned specialist provider. The number of registered carers has grown by 20% over the past two years and we continue to register carers at a rate of around 400 per month. The pandemic, together with cost-of-living worries, has seen more carers register and use carer response lines The carer population is West Sussex is likely to be around 120,000.

In terms of equality, mapping has demonstrated carers are being reached in all areas of the county e.g., urban, rural, low and high levels of deprivation. There are also successful initiatives to engage with carers from the most vulnerable communities e.g. Bi-lingual counselling, a new bi-lingual buddy scheme in Crawley and Pride in Care Accreditation (LGBT+) has been awarded to Carer Support West Sussex.

Adult Social care undertake some statutory carers assessments but, in most instances, following the outsourcing of the function, assessments are referred to colleagues at CSWS. Numbers were down due to pandemic but are now growing again to pre pandemic levels e.g., around 90 full statutory carer assessments per month (1,000 p.a.)

The Countywide Carer Information, Advice, Assessment and Support Service, provided by CSWS, provides a good quality service to carers. They keep significant 'traffic' away from busy primary care settings and social work teams. Their response lines provide an initial point of contact for carers, when they need help, via phone, email, and an online chat service.

Reasons/themes for carers making contact includes isolation, bereavement, anxiety, hospital appointments and discharge, funding, low-level emotional support, pandemic/vaccination questions, care home issues, contingency planning, and hospital admissions.

The financial disadvantages of caring have long been understood. In recent years however this has become a more pressing issue. Last year:

- A new Carer Welfare Benefits' Service, advised on £1,406,954 in additional annual income for carers, supporting 737 carers.
- £521,000 in wellbeing and hardship grants to 1,702 unique carers were paid (DHSC Funds). 95% of carers say the funds have helped them feel less anxious or stressed about their caring situation; and 94% say they have helped improve their health and wellbeing.
- 6,870 carers received a £50 supermarket voucher to help with essentials during a time of rising costs. (DHSC Funded).

Customer satisfaction with CSWS is consistently high and this year saw the implementation of the Carers Outcome Star Tool. This will enable better measurement of carer outcomes/ distance travelled, where there are longer term interventions.

In addition to the above, there are other services/contracts including:

- The BCF-funded Carer Health Team (SCFT) is the first of its kind in the country and was commissioned to address the needs of adult carers in response to an identified issue of carer neglecting their own health. The specialist clinicians target carers, usually older carers, whose health is beginning to deteriorate as a result of their caring roles. This service compliments other support services locally. The service has been recognised by NICE as good evidence-based practice.
- Carer respite/breaks at home. One to one support (planned and Emergency) for the carers of frail elderly and or living with dementia.
- Carer respite/breaks away from home (a range of different group models provided by a range of commissioned partners) for the carers of frail elderly and or living with dementia.
- Carer Bereavement Support.
- Support for carers back into training or into work (paid or voluntary).
- There is a young carers service and groupwork programme benefitting over 1,000 young carers aged 5 to 18 years.
- A young adult carers service (18-25 years) a small but unique group.

The aim, in respect of the carer care pathway is to achieve the right support at the right time and to support carers at every stage of their caring journey:

From:

- Becoming a carer.

- Specialist clinical input if health is affected,
- Supporting in hospital and at discharge.
- Providing benefits advice and emergency payments in the case of hardship.

Through to:

- Bereavement support, and:
- Support in employment or to return to work.

The carers offer is regularly reviewed with carers of all ages and there is a 'Carer Voice Network' of around 20 carers that are available for consultation and co-design purposes.

There is clear evidence that investing in services for carers not only improves health and wellbeing outcomes for patients and recipients of care, but also improves health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health. The West Sussex Better Care Fund scheme, Carers Services, supports unpaid carers by providing a range of services which include:

- Carers Information, Support, and Advice: Empowering Carers, increasing their resilience, supporting their wellbeing, and delivering statutory carers assessments in accordance with the Care Act 2014 and relevant regulations, guidance and policies.
- Carers Support in Hospitals: To provide immediate support to people in a hospital setting, who as a result of a hospital admission of a family member can suddenly find themselves in a caring role or with increased caring responsibilities, and to refer onward to community base carer support services at the point of discharge.
- Carers Health Team: To ensure carers feel less isolated, stay mentally and physically fit and maintain their wellbeing and life outside their carer role.

7 Disabled Facilities Grant and Wider Services

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.

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.

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.

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.

As a member the West Sussex Health and Care Partnership Executive, NHS Sussex 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 NHS Sussex 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. NHS Sussex 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.

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.

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.

The WSCC Community Occupational Therapy Service 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.

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.

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.

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.

8 Equality and Health Inequalities

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 in Crawley, Bognor, Littlehampton, and Worthing ranking amongst the 20% most deprived 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.

Many health inequalities exist within the county. We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions. The Core20Plus5 approach sets out a model to support integrated care systems to focus on health inequalities by identifying local areas of focus linked to deprivation and outlining the 5 key clinical areas for health inequalities:

- Maternity – equity and continuing care.
- Serious Mental Illness (SMI) – access to health checks.
- Chronic Respiratory Disease – reduction of exacerbations and increase access to COVID, Flu and Pneumonia vaccine.
- Early Diagnosis of cancer.
- Hypertension case finding.

We will also focus on identified and prioritised population groups that are experiencing health inequality and disadvantage. In West Sussex these are identified as:

- Carers.
- Asylum Seekers and Refugees.
- Maternity access for Black, Asian and other Minoritized communities.

The COVID pandemic highlighted the disparities in health and care access for deprived communities and Black, Asian and other Minority Ethnic communities. This is not 'new news'; the Marmot Review 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. The COVID pandemic has brought these disparities front and centre and over the past 18 months we have seen significant interventions to reduce these disparities in access, despite this there is still much to be done and the need for better understanding of how community assets can support engagement.

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. This partnership approach is being seen delivered through Local Community

Networks (LCN's). LCN's are delivering a strong collaborative, partnership approach which provides opportunities 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.

There are 6 LCNs covering West Sussex which reflect partner capacity to engage whilst also supporting working at scale. These LCNs enable the 20 West Sussex Primary Care Networks (PCNs) (which formulate the NHS structured neighbourhoods' approach) to work with partners and communities to tackle health inequalities and develop more locally based joint initiatives to improve the health & wellbeing of the population.

LCNs agree priorities for collaborative working as a system to reduce inequalities based upon local intelligence, data, articulated system priorities and community derived insight. Across West Sussex this activity to tackle health inequalities forms a golden thread which reflects the vision that locally agreed priorities provide a Place Based Approach for collaboration for the Sussex wide Integrated Care System.

Membership of each LCN includes:

- County and District/Borough tiers of local government, including Public Health
- Health – NHS Sussex and PCNs
- Voluntary Community Sector
- Community voice

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.

Working to our place-based plan, 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.

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.

We will prioritise the improvement of healthy life expectancy through tackling the key health inequality related conditions and ill health. Social Prescribing and the other personalised care roles are key to supporting those who are most at need to access preventative care and support and well as supporting engagement in community level interventions to decrease isolation.

We know that addressing those inequalities is often and best done at neighbourhood 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 how we commission and provide services, 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 requires a long-term view and that there are no quick fixes. This can be 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.

Our key shared priorities for addressing health inequalities are:

- Early Cancer Diagnosis including access to screening – We will continue to work with partners and develop population focused plans which plan to tackle issues of poor screening uptake and late presentation of cancers by understanding the reasons and barriers to accessing screening and 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.

Reducing disparities in health care access based on ethnicity and increasing opportunities for individuals and communities from Black, Asian and other minoritized ethnic communities, including refugees and asylum seekers to be able to access primary and secondary healthcare. This includes reducing the fear of financial

challenge or risk of reporting to other government agencies. Health Inequalities delivery priorities for 2022-23, refreshed since the previous BCF plan, are:

- The establishment of the Health Inequalities Delivery Group for West Sussex Place. This delivery group will support the West Sussex Partnership Group and support the ICS Health Inequalities Programme. This delivery group will provide strategic oversight and oversee delivery health inequalities programmes.
- The Crawley Programme will be supported through engagement with the Crawley Local Community Network.
- West Sussex wide information, learning, engagement, reporting and governance structures will continue to be supported, working with partners in order to produce a locally sensitive but countywide approach to tackle health inequalities.
- The work addressing inequalities amongst Black, Asian and minoritized ethnic communities will expand across West Sussex, building on the existing work and focused on locations that are more densely populated by minoritized ethic communities to ensure that further inequality is not created. This work will include developmental work to support increased access by Gypsy, Roma and Traveller communities and programmes to support Refugee and Asylum Seekers including a targeted social prescribing programme.
- 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.
- Developmental work to support the ongoing delivery of Social Prescribing with a focus on supporting a Sussex wide view of the development of services moving forward from 2023. Including the development of digital tools to support recording and reporting of services and a wider understanding of generalism v's specialism in social prescribing. Support will be given to understand how the delivery of services for children and young people can be provided across West Sussex.

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.

The cost-of-living Crisis is a key conversation and the challenges for our population and current patients is an identified priority for all our system partners. Whilst there is an understanding that the cost-of-living crisis will impact throughout all populations there will be some groups that are disproportionately affected in a similar way to disparities found with the impact of Covid, for example those who are already living in poverty, from minority ethnic groups, or who are on low or minimum wage, older people, people with long term conditions, carers and families.

Collaborative efforts across local community networks working with local and upper tier authorities, NHS Sussex, Citizens Advice, Healthwatch and VCSE organisations are

working through opportunities to support communities and individuals, but these opportunities are limited.

Social prescribers have noted that finance and cost of living is a key issue for many of their referrals, it is expected that these referrals will continue through the cost-of-living crisis and the risk to increased poor physical and mental health, including risk of suicide, is becoming an increasing concern.

There are concerns for many organisations, including VCSE organisations that they will struggle with organisational costs including heating costs and are not able provide an appropriate cost of living uplift to all staff. This in turn risks services for the most vulnerable which may well impact upon future need for NHS services in the months and years to come.

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. Social Prescribing is a key personalised care tool to support the reduction of health inequalities. There is an increasing view that whilst primary care roles can provide generalist interventions there is also the need for specialism in social prescribing focusing on some of those communities that are most at need including BAME, LGBT, LD, Older People, Carers, Asylum Seekers and Refugees and Gypsy, Roma, Traveller communities.

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.

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 and supporting improved outcomes.

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