West Sussex Health and Wellbeing Board

Better Care Fund Narrative Plan 2023-25

1 Stakeholder Engagement

1.1 The following bodies are represented at the West Sussex Health and Wellbeing Board which has statutory responsibility for the Better Care Fund:

- West Sussex County Council.
- NHS Sussex Integrated Care Board.
- 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 The West Sussex Health and Care Partnership brings together key local health and care partner organisations including NHS Trusts, Primary Care, and Public Health to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a place-based focus on the Shared Delivery Plan.

1.3 This supports the delivery of our locally agreed plans and programmes of transformation for the recovery, stabilisation and future sustainability of our health and care system. Our aim is to work together as a system to ensure a focus on prevention and deliver high quality, effective care, and improved health outcomes, and the operational models that enable this, for the population in West Sussex.

1.4 Through a partnership approach the West Sussex Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a 5-year integrated local West Sussex Plan which forms part of the Sussex-wide Integrated Care Strategy Improving Lives Together.
2. Supporting the delivery of initial agreed priority programmes of transformation in three core areas of urgent care, planned care and community services, and

3. Ensuring engagement with the delivery of the plans and collectively tackling the issues and challenges we face as a system.

1.5 We work with our citizens in a range of ways to ensure that the way our priorities are delivered fits with what people have told us is important about their health and care and engage system partners to discuss specific aspects of the West Sussex BCF plans and ensure a collaborative and cohesive approach to their development.

1.6 In addition to approval of the plan there is ongoing and regular stakeholder engagement via established forums. For example, with our providers in respect of discharge planning and monitoring, system performance, capacity, and demand planning, and at individual scheme level with NHS providers, social care 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.

2 Governance

2.1 The West Sussex Health and Wellbeing Board retain statutory 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 to monitor performance and expenditure are defined in the Section 75 Agreement.

2.2 The West Sussex Health and Wellbeing Board meets regularly as a statutory committee of the County Council. It is responsible for the Joint Health and Wellbeing Strategy and performs a system oversight and accountability role. This ensures, 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 streamline the way that services work.

2.3 The West Sussex Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide Improving Lives Together strategy through a place-based focus derived from the five-year Shared Delivery Plan as built upon the Health and Wellbeing Strategies of the three Sussex 'places' of Brighton and Hove, East Sussex, and West Sussex. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board. Having a place-based partnership allows us to adapt our working to the specific population needs that we have in West Sussex and use our local assets to deliver solutions.

2.4 The Integrated Care Partnership - Sussex Health and Care Assembly is a statutory joint committee set up between NHS Sussex, Brighton & Hove City Council, East Sussex County Council and West Sussex County Council. Its membership includes representatives from universities, voluntary and community organisations, Healthwatch, further education, housing and local enterprise, across Sussex. It formally agree the strategic direction for our wider system. Although each organisation is responsible for decisions about its own priorities and resources, we want to use the approach outlined in Improving Lives Together to keep us focussed on the things we can only achieve well by working together.

2.5 The West Sussex Better Care Fund plan is developed and delivered within the context set by the:

- Start Well, Live Well, Age Well: West Sussex Joint Health and Wellbeing Strategy 2019 – 2024:
    - http://www2.westsussex.gov.uk/ds/cttee/hwb/jhws2019to2024.pdf
- Improving Lives Together: Our ambition for a healthier future in Sussex - built upon the Health and Wellbeing Strategies of the three Sussex 'places':
    - https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2023/01/0438-NHS-Sussex-VF4-4.pdf

- Improving Lives Together: Sussex Integrated Care Board Shared Delivery Plan – five year Shared Delivery Plan including specific West Sussex ambitions and actions.
- The Life You Want to Lead: West Sussex Adult Social Care Strategy 2022-2025:
    - https://www.westsussex.gov.uk/social-care-and-health/publications-policies-and-reports/social-care-and-health-policy-and-reports/adult-social-care-strategy/

2.6 How the application of the Better Care Fund, including the Discharge Funds, supports the delivery of the Sussex Shared Delivery Plan, is captured through the Sussex system oversight governance arrangements. West Sussex governance arrangements link to the Shared Delivery Plan and System Oversight governance that encompasses health and social care, to ensure alignment of plans and benefits realisation through the current and future deployment of the Better Care Fund.

3 Executive Summary

3.1 For 2023-25, the national Better Care Fund programme is underpinned by two core policy objectives, to:

- Enable people to stay well, safe and independent at home for longer.
- Provide people with the right care, at the right place, at the right time.

3.2 In addition, the programme supports key priorities in the NHS Long Term Plan and the government's plan for recovering urgent and emergency care (UEC) services, and the continued delivery of more joined-up care across health and social care, aligning with key priorities for the health and care system:

- Improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services.
- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

3.3 The West Sussex BCF Plan for 2023-25 is aligned to the integrated care strategy, Improving Lives Together, and the ambition and objectives of the Shared Delivery Plan.

3.4 A central feature of this two-year plan is the requirement to produce a Capacity and Demand Plan for Intermediate Care Services, initially for 2023/24, supporting both discharge and community referrals. There is a requirement to refresh this for winter in October 2023, and plans for 2024/25, capacity and demand, metrics, and expenditure, will be refreshed in Q4 2023/24.

3.5 The BCF funded schemes are carried forward from the previous year with the following additions:

- Discharge Fund: LA Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Q4 2022/23.
- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

Income and Expenditure

Table 1 Income

Income Source	2023/24	2024/25
Minimum Contribution – NHS Sussex ICB	£71,359,292	£75,398,228
Adult Social Care Discharge Fund: ICB Allocation	£5,295,816	£7,521,311
Adult Social Care Discharge Fund: LA Grant	£2,889,864	£4,797,174
Disabled Facilities Grant	£9,414,970	£9,414,970
Improved Better Care Fund	£20,612,666	£20,612,666
Minimum Contribution c/f from 2022/23	£522,225	£0
Total	**£110,094,833**	**£117,744,348**

Table 2 2023/24 Expenditure Plan

Committed Funding Scheme	Scheme Number	NHS Sussex	West Sussex County Council	Committed Funding
Disabled Facilities Grant	1	£0	£9,414,970	£9,414,970
Maintaining (Protecting) Social Care	2	£19,729,256	£0	£19,729,256
iBCF: meeting adult social care needs	3a	£0	£11,206,666	£11,206,666
iBCF: reducing pressures on the NHS, including seasonal winter pressures	3b	£0	£4,550,000	£4,550,000
iBCF: ensuring that the social care provider market is supported	3c	£0	£2,360,000	£2,360,000
iBCF: supporting more people to be discharged from hospital when they are ready	3d	£0	£2,496,000	£2,496,000
Proactive Care	4	£7,967,096	£0	£7,967,096
Communities of Practice	5	£4,751,344	£0	£4,751,344
BCF Programme Supt	6	£320,660	£0	£320,660
Responsive Services	7	£18,671,151	£0	£18,671,151
Social Prescribing	8	£486,171	£0	£486,171
Stroke Recovery Service	9	£264,759	£0	£264,759
Combined Placement and Sourcing Team (ICB contribution)	10	£814,595	£0	£814,595
Community EOL Admission Avoidance	11	£888,782	£0	£888,782
Care Act Initiatives	12	£1,277,400	£0	£1,277,400
Carers Services	13	£3,448,000	£0	£3,448,000
Technology Enabled Care	14	£1,171,900	£0	£1,171,900
Community Equipment	15a	£4,381,000	£0	£4,381,000
Community Equipment (Health)	15b	£6,637,847	£0	£6,637,847
ICB non NHS uplifts-allocation	16	£154,927	£0	£154,927
Hospital Discharge	17	£916,629	£0	£916,629
ASC DF LA Grant funded schemes	18	£0	£2,889,864	£2,889,864
ASC DF ICB Allocation funded schemes	19	£5,295,816	£0	£5,295,816
Total:		**£77,177,333**	**£32,917,500**	**£110,094,833**

Notes:

1. This plan meets the minimum spend requirements of £29,840,556 for social care, and £20,278,287 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).

Table 3 2024/25 Expenditure Plan

Committed Funding Scheme	Scheme Number	NHS Sussex	West Sussex County Council	Committed Funding
Disabled Facilities Grant	1	£0	£9,414,970	£9,414,970
Maintaining (Protecting) Social Care	2	£20,845,932	£0	£20,845,932
iBCF: meeting adult social care needs	3a	£0	£11,206,666	£11,206,666
iBCF: reducing pressures on the NHS, including seasonal winter pressures	3b	£0	£4,550,000	£4,550,000
iBCF: ensuring that the social care provider market is supported	3c	£0	£2,360,000	£2,360,000
iBCF: supporting more people to be discharged from hospital when they are ready	3d	£0	£2,496,000	£2,496,000
Proactive Care	4	£8,389,352	£0	£8,389,352
Communities of Practice	5	£4,926,957	£0	£4,926,957
BCF Programme Supt	6	£320,660	£0	£320,660
Responsive Services	7	£19,660,722	£0	£19,660,722
Social Prescribing	8	£486,171	£0	£486,171
Stroke Recovery Service	9	£264,759	£0	£264,759
Combined Placement and Sourcing Team (ICB contribution)	10	£814,595	£0	£814,595
Community EOL Admission Avoidance	11	£888,782	£0	£888,782
Care Act Initiatives	12	£1,349,701	£0	£1,349,701
Carers Services	13	£3,643,157	£0	£3,643,157
Technology Enabled Care	14	£1,238,230	£0	£1,238,230
Community Equipment	15a	£4,628,965	£0	£4,628,965
Community Equipment (Health)	15b	£6,115,622	£0	£6,115,622
ICB non NHS uplifts-allocation	16	£311,614	£0	£311,614
Hospital Discharge	17	£1,513,010	£0	£1,513,010
ASC DF LA Grant funded schemes	18	£0	£4,797,174	£4,797,174
ASC DF ICB Allocation funded schemes	19	£7,521,310	£0	£7,521,310
Total:		**£82,919,538**	**£34,824,810**	**£117,744,348**

Notes:

1. This plan meets the minimum spend requirements and funding allocation but is provisional pending the required submission of refreshed expenditure plans for 2024/25 due in Quarter 4 of 2023/24.

Metrics

3.6 The BCF planning submission requires metrics to be set for 2023/24 only. For 2024/25, revised metrics, including a new discharge metric and replacement of the current metric for Reablement will be set in a plan refresh due in Q4 2023/24.

Table 4 Avoidable Admissions

Avoidable Admissions:	Q1	Q2	Q3	Q4
2022/23 Actual Indicator Value:	147.5	124.0	120.2	TBC
2022/23 Number of Admissions:	1,646	1,384	1,341	TBC
Population:	863,980	863,980	863,980	863,980
2023/24 Planned Indicator Value:	**142.9**	**120.3**	**117.8**	**120.2**

3.7 This metric is a measure of emergency admissions 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.

3.8 Assumes negligible anticipated growth on non-elective activity and no change in seasonal pattern or significant change in population. The 2023/24 ambition is for a 3% nominal reduction in avoidable admissions during each quarter compared with 2022/23 activity levels, delivered through Sussex-wide emerging plans.

3.9 The Sussex-wide ambition is to maintain improvements seen since Q4 2021/22 as the system stabilised following the pandemic. Further improvements are anticipated through schemes targeting specific conditions (under the Ageing Well, Frailty, and Long-term Conditions Programmes), and the roll-out of the Virtual Wards Programme which includes an admission avoidance component. All these schemes are expected to deliver benefits during 2023/24. A number of further West Sussex BCF-funded schemes support admission avoidance. In particular, we have well-established community-based, multi-disciplinary PCN teams, Proactive Care and Communities, who work closely with Primary Care.

Table 5 Falls

Falls:	2021/22 Actual	2022/23 Estimated	2023/24 Plan
Indicator Value:	2,314.9	2,121.8	**2,058.1**
Count:	5,125	4,694	**4,553**
Population	202,708	202,708	**202,708**

3.10 This metric measures emergency hospital admissions due to falls for people over 65.

3.11 Assumes negligible anticipated growth in non-elective activity and no change in seasonal pattern or significant change in population. The 2023/24 ambition is for a 3% nominal reduction in avoidable admissions during each quarter

compared with 22/23 activity levels, delivered through Sussex-wide emerging plans and West Sussex specific initiatives.

3.12 Improvements are anticipated through a variety of initiatives, including: the continued development of non-injured falls pathway to maximise utilisation of Community First Responders and Urgent Community Response rather than the ambulance service, continue the delivery of level 1 and 2 falls service as an integrated part of Urgent Community Response, expansion of referrals to Sussex Community Falls Services including self-referrals, increased referrals into Urgent Community Response and falls response from 999/111, Care Homes and alternate providers. This ambition is supported by BCF-funded schemes such as Responsive Services (including Urgent Community Response and reablement/rehabilitation) and Technology Enabled Care.

Table 6 Discharge to Usual Place of Residence

Discharge to Usual Place of Residence:	Q1	Q2	Q3	Q4
2022/23 Numerator:	15,492	15,595	15,513	TBC
2022/23 Denominator:	17,811	17,656	17,312	TBC
2022/23 Actual:	87.0%	88.3%	88.5%	TBC
2023/24 Numerator:	16,104	15,942	15,741	16,028
2023/24 Denominator:	18,141	18,016	17,787	18,056
2023/24 Plan:	**88.8%**	**88.5%**	**88.5%**	**88.8%**

3.13 Assumes negligible anticipated growth in non-elective activity and no change in seasonal pattern or significant change in population. Stretch target set at 2% increase on previous year's targets, with same phasing, but with a minimum ambition of 88.5%. West Sussex figures for discharge under Pathways 0 and 1 tend to be lower than those in our neighbouring areas. 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 rehabilitation or reablement to get them home, is larger in both scope and size than that in the other Sussex HWB areas. 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. The mobilisation of the Sussex strategy from October 2023 to reach 95% ambition incrementally during 2024/25 may positively impact performance but West Sussex has farther to go for the reasons stated above.

3.14 The discharge model for Sussex will be finalised during Q2 2023/24 as part of the Discharge Front Runner programme and mobilised during Q3 & Q4. This plan will build on proposals developed during 2022/23 and underpinned by analysis of the approaches across the 3 Sussex places, identifying a key focus on Home First services. These will have the greatest impact on both patient outcomes and system flow. Many of these schemes are funded via the West Sussex Better Care Fund including a wide range of intermediate care, community equipment and other assistive technology, discharge support and urgent response services.

Table 7 Residential Admissions

Residential Admissions:	2021/22 Actual	2022/23 Plan	2022/23 Estimated	2023/24 Plan
Numerator:	951	1,244	1,091	**1,063**
Denominator:	200,968	208,802	208,802	**212,751**
Annual Rate:	473.2	595.8	522.6	**499.6**

3.15 This metric serves as an overarching measure, delaying and reducing the need for care and support.

3.16 Performance in 2022/23 demonstrated a recovery from the unrepresentative patterns of admission following the impacts of Covid-19. West Sussex is continuing to work towards reducing new admissions to residential settings, while increasing non-residential options. This has been effective and the percentage of res to non-res customers has been moving in the right direction, however the average cost of placements is increasing, due to market pressures and complexity of customer need. Due to increased demand and reduced market capacity, we are experiencing significant wait times in all areas of the business. This means the current performance may be impacted by individuals having to wait longer before a placement can be identified, which may show as an over estimated reduction in new admissions. Restoration remains 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 whilst being reset based on actual performance seen in recent years.

3.17 For 2023/24, our BCF-funded and non BCF-funded services continue to support a home first approach to hospital discharge, coupled with reablement / rehabilitation support, and other intermediate care services, enabling people to stay well, safe and independent at home for longer. Many of our BCF schemes will contribute to reducing residential admissions. For example, many of the services provided under Scheme 2 - Maintaining (Protecting) Social Care, Scheme 7 – Responsive Services, or the targeted use of the Disabled Facilities Grant.

Table 8 Reablement

Reablement:	2021/22 Actual	2022/23 Plan	2022/23 Estimated	2023/24 Plan
Numerator:	119	228	165	**199**
Denominator:	198	291	280	**292**
Annual Rate:	60.1%	78.4%	58.9%	**68.2%**

3.18 This metric 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.

3.19 Performance continues to be below the target set and this metric, no longer part of the Adult Social Care Outcomes Framework, is problematic as recognised in the ADASS review. West Sussex has no control over what happens to a customer once discharged from the reablement service and we

have had continued difficulties contacting customers, which impacts negatively on performance. If we are unable to contact the customer or the customer does not respond, then the guidance requires us to record these as not at home. There has been an increase to the level of dependence and complexity of people referred to the reablement service over the last 12 months. This is due to an increase in dependency in the relevant population, particularly those being discharged from hospital, and also an increased focus on ensuring as many people as possible benefit from referral to a reablement service, so a wider application of the criteria for the service. For 2023/24 and given the issues discussed above, we are setting a more realistic target seeking to improve performance, as recorded by this measure, over that of previous years.

3.20 West Sussex will continue to ensure there are effective out of hospital services and that people are supported in their own homes. For 2023/24, 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, enabling them to stay well, safe and independent at home for longer.

4 National Condition 1: Overall Approach to Integration

4.1 The integrated care strategy, Improving Lives Together, sets out the ambition across health and care in Sussex over the next five years, building upon the existing Health and Wellbeing Strategies for each of the three Sussex places. Its aim is to improve the lives of local people by supporting them to live healthier for longer and making sure they have access to the best possible services when they need them.

4.2 Whilst the Health and Wellbeing Strategies focus on the priorities across local populations, Improving Lives Together identifies the areas where a positive difference to people's lives that can be best achieved by working across the whole of Sussex:

- A new joined-up community approach to health and care.
- Growing and developing our workforce.
- Improving the use digital technology and information.
- Maximising the power of partnership working.

4.3 We will be strengthening how our organisations work formally in partnership across our populations at Place to deliver joined-up care and improve health, co-ordinated through Health and Care Partnerships whose work is overseen by the Health and Wellbeing Boards.

4.4 The West Sussex Joint Health and Wellbeing Strategy 2019-2024 sets out the Health and Wellbeing Board's vision, goals and ways in which we will work to improve health and wellbeing for all residents in West Sussex. It was developed in consultation and collaboration with local residents, service users, multi-disciplinary professionals and partners. It draws on evidence of West Sussex's health and wellbeing needs from the joint strategic needs assessment.

4.5 The strategy adopts a life course approach, identifying our priorities across three themes - Starting Well, Living and Working Well and Ageing well. It consists of a few carefully selected priorities that can significantly contribute towards achieving its vision with a focus on:

- A whole system approach to prioritise prevention, deliver person centred care, and tackle health inequalities.
- Harnessing the assets and strengths of local communities to improve health and wellbeing, creating safe, sustainable environments that promote healthy living.

4.6 The West Sussex Health and Care Partnership was formed in 2020, bringing together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint Health and Wellbeing Strategy and the Sussex-wide strategy through a Place-based Plan. The partnership leads on delivering shared population health objectives on behalf of the Health and Wellbeing Board. Having a place-based partnership allows us to adapt our working to the specific population needs that we have in West Sussex and use our local assets to deliver solutions, improving health and care outcomes and addressing health inequalities

4.7 We have developed a model of collaboration that brings changes to people directly within their community, through our Local Community Networks. These are co-located with district and borough footprints and are empowering communities to deliver change through collaborative working between primary

care, district and borough councils, local Public Health, and voluntary sector enterprises.

4.8 Through collaboration, the West Sussex Health and Care Partnership will support the Improving Lives Together strategy and deliver on the priorities set out in our place based plan:

- Address health inequalities – There are stark inequalities in outcomes, access, and experience of care for maternity and neonatal service user's and the opportunities and experience of staff from minority backgrounds and we will tailor our services to target the needs of our local populations and offer a personalised maternity journey that wraps around the individual and their family. 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 need 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.
- Integrate 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.
- Transform 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.

4.9 In addition, West Sussex has identified six specific place-based priority areas for change to be delivered over five years each with specific targets for 2023/24:

1. Tackling the wider determinants of health: Our partnership will work together to influence the many determinants of healthy living, such as how services are accessed and how communities can be empowered to support healthy living for their residents. This is being done by:
    a. Delivering our Crawley transformation programme with new models for accessing health and care.
    b. Tackling the heart of health inequality experienced by communities within West Sussex, using public health data to target resources to close the gaps in health inequalities within communities.
    c. Building on our commitment to social prescribing to support people with managing their health with help and support.
2. Addressing health inequalities: We will have a targeted and focused approach for those with most need and who need additional support. This is being done by prioritising the key health inequality related areas such as heart disease, respiratory illness and cancer and utilising approaches such as tobacco control,

targeted cancer screening and health checks to target activity and resources where it is needed most based on local evidence.

3. Adults Services: Our strategic objective is to help people 'live the life they want to lead', by remaining independent for as long as possible and maintain a high quality of life. Building on our early models of integrated health and social care, we want to grow our model of care in the community to deliver more health services and care to people in their home-setting and local community, supporting people living with long-term conditions.

4. Children and Young People: We will improve the existing support to children and young people so they can have the best possible start to live. This is being delivered through our health priorities set out in our West Sussex Children First programme, improving maternity experiences amongst more deprived people, delivering the best standard health-checks for children who are in care, and developing new services and support for the emotional wellbeing of all young people.

5. Mental Health: We will expand our support for people with mental health needs to address the growing need. We aim to deliver the best standard physical health checks for people with mental illness, and to develop sustainable housing solutions for people living with long-term mental illness, linking to our Health, Housing and Social Care Memorandum of Understanding.

6. Learning Disabilities and Neurodevelopmental Needs: We will provide greater focus and support for those with a learning disability and neurodevelopmental needs. We are reforming our children's and young people's neurodevelopmental diagnosis and care pathway, including social support. We want to ensure regular high-standard health checks for people with a learning disability, and we want to create more long-term paid employment opportunities for people with a learning disability.

4.10 Our six Local Community Network (LCN) boundaries align with West Sussex District and Borough Council boundaries. Some Primary Care Network boundaries are within two LCNS. Joining up our communities means health, social care and the wider determinants of health such as education, housing and employment work together with local communities to meet the needs of those communities; addressing health inequalities and improving health outcomes via collaboration between primary care, public health, two tier local governance and local voluntary sector enterprise.

4.11 These form the foundation of our community model complimenting and building on existing community assets, such as Health and Well Being Hubs commissioned through Public Health.

4.12 We will establish Integrated Community Teams at the most appropriate level, combining to provide a holistic care model for local communities. We will also continue to develop specialist integrated community teams such as integrated intermediate care.

4.13 There is no joint commissioning within our BCF plan although the ICB collaborated extensively in the recent procurement of our Integrated Community Equipment Service. Rather, each partner commissions their own schemes but these are overseen and monitored by the Joint Commissioning Strategy Group, which has a similar remit in respect of our separate joint commissioning Section 75 Agreement covering Children and Young People, and

Mental Health and Learning Disabilities for which delegated arrangements apply.

4.14 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. In developing recommendations for the future of joint commissioning we will need to consider:

- Alignment with the West Sussex Joint Health and Wellbeing Strategy, the Sussex Integrated Care Strategy, and the Shared Delivery Plan.
- The strategic direction of partnership working between the ICB and NHS provider organisations within the ICS.

4.15 We will 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.

4.16 For 2023-24, 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 by:

- Retaining a strong focus on supporting discharge.
- Providing core Intermediate Care Services.
- Supporting the development of Local Community Networks and developing the existing multi-disciplinary teams within the BCF programme, bringing together proactive care and community nursing teams, into a universal model of Integrated Community Teams across all of West Sussex place.
- Supporting Care Act duties and BCF requirements in relation to reablement and carers breaks.
- Meeting the specific requirements of the Disabled Facilities Grant Improved Better Care Fund, and additional Discharge Funding.

5 National Condition 2 – BCF Objective 1: Enabling People to Stay Well, Safe and Independent at Home for Longer

5.1 West Sussex will enable people to remain independent, where possible, in their own home, to 'live the life they want to lead' and maintain a high quality of life. We will do this by addressing health inequalities and growing our model of care in the community. The model of collaboration through Local Community Networks, described in Section 4, supports this ambition.

5.2 We will develop a new integrated intermediate care model for rehabilitation and reablement services, improving the support to help more people remain in their own home while they recover from a hospital stay. This will enable us to ensure people receive care in a timely manner, through teams working together in reducing unnecessary duplication and handovers.

5.3 People will be better supported to remain at home and retain more independence in the community through:

- Reduced time waiting to receive reablement/intermediate care intervention.
- Reductions in people unnecessarily needing long term care.
- Reductions in need for care home placements.
- Increased proportion of care provided at home.
- Greater personalisation of discharge care and increase in number of personal health budgets.
- Increase in proportion of people living independently at home for longer.

5.4 Over the next five years we will integrate health, social care, and health-related services across local communities in a way that best meets the needs of the local population, improves quality and reduces inequalities. This will involve us working with local people to build on what works best already, and to create a multidisciplinary workforce, tailored to the health and care needs of the community. We will do this by developing Integrated Community Teams, that are made up of professionals working together across different organisations within local communities. This will involve integration across primary care, community, mental health, local authority partners, VCSE and other local partners.

5.5 We will develop a 'core offer' that each Integrated Community Team delivers to everyone, in addition to the individual support and services available to meet the specific needs of different communities. This new service model will be enabled by the delivery of our digital and workforce priorities, meaning our workforce has more time for direct care and to focus on population health management, prevention, and community engagement.

5.6 Prevention is a key principle that underpins the delivery of our ambition. This includes supporting: good physical health; people to be socially connected; emotional wellness and positive mental wellbeing; people to feel safe; and a clean and sustainable environment. Prevention is a core focus which we will develop further through our Integrated Community Teams.

5.7 Our joined-up community working will enable health, social care and the wider determinants of health such as education, housing and employment to work together with local communities to meet the needs of those communities; addressing health inequalities and improving health outcomes.

5.8 Our learning from 2022/23 informed our capacity and demand planning with particular reference to:

- data is not necessarily held in the currencies and structure required for the submission. Therefore, where estimates have been made, we continue to make adjustments as the data is developed and understanding is enhanced.
- some services are block and the nature of the contract does not provide us with historic activity data. We have based capacity on demand in some of these cases.
- Most services (unless bedded) have a flexible workforce to handle changes in demand across the year. Where referrals did not meet expectations, capacity flexed.

5.9 Our approach to capacity and demand planning is built upon the following assumptions:

- Demand for 'Urgent Community Response' is based on referrals received in 22/23, excluding those received from acute services.
- Demand for other services arising from community sources is based on best estimates and analysis of supporting Hospital Discharge estimates.
- Reablement and Rehabilitation at Home and in a bedded setting are as for Hospital Discharge
- Capacity is linked to demand as the best current indicator of capacity.

5.10 Demand and capacity planning is aligned with the discharge programme to ensure sufficient onward flow from Urgent Community Response is in place to optimise capacity and capability to managed increased demand from 999/NHS111 and other referral sources. Based on peak demand no significant capacity gaps have been identified however further work to refine the data is being undertaken as part of the Discharge Front Runner programme and this will include data for mental health pathways.

5.11 Several of our Better Care Fund schemes will support delivery of this objective.

5.12 The longstanding BCF schemes, Communities of Practice (North West Sussex) and Proactive Care (Coastal West Sussex) established multi-disciplinary team working, including adult social care, at PCN level. We will review and reconcile these models into a universal model of Integrated Community Teams across all of West Sussex place.

5.13 A significant proportion of Intermediate Care services in West Sussex are funded by the Better Care Fund via the Maintaining (Protecting) Social Care and Responsive Services schemes, including:

- Reablement services provided by both West Sussex County Council and Sussex Community NHS Foundation Trust.
- Community hospital beds.
- Community nursing.
- Urgent community response/Admission avoidance.
- Enhanced health in care homes.
- Rehabilitation services.

5.14 Although assigning attribution at individual scheme level can be difficult, the funded services together with the overall approach to supporting this policy objective are expected to have a positive impact on unplanned admissions to hospital for chronic ambulatory care sensitive conditions, emergency hospital admissions following a fall for people over the age of 65, and the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

6 National Condition 3 – BCF Objective 2: Provide the Right Care in the Right Place at the Right Time

6.1 West Sussex recognises the imperative to provide the right care in the right place at the right time. Our plan to grow our model of care in the community, the model of collaboration through Local Community Networks described in Section 4, and our discharge ambitions at place as part of our Sussex-wide Shared Delivery Plan supports this ambition.

6.2 Sussex-wide initiatives provide the context and framework for place-based working and ambition. During 2023/24 a key focus is improving discharge to free up more capacity to allow more people to be cared for in a timelier way:

- Support each of our acute hospital sites to undertaken improvement work within their emergency departments, including a focus on rapidly streaming people to the right service.
- There will be improved flow of people through emergency departments, enabling ambulances to be offloaded and minimising the time that people spend in departments before being discharged or admitted.

6.3 As a Discharge Frontrunners site, our goal will be to bring together a comprehensive model of integrated hospital discharge that meet the needs of our three places. It will support good system flow with reduced lengths of stay, admission avoidance, and better long-term outcomes for our population.

6.4 During 2023/24:

- We will develop and mobilise a multi-agency workforce plan based on agreed discharge demand and capacity requirements - We will right-size our health and care workforce to enable us to build the right capacity in home care or posthospital bedded care to meet the needs of our population.
- We will evaluate and select a small number of digital innovations which will best support improvements in the discharge pathways, alongside the development of a shared data architecture to provide visibility of patient flow and capacity - We will support more efficient use of our workforce, improved patient experience and seamless working between health and care colleagues.
- We will develop an economic model for Discharge in Sussex which enables us to make best use of available funding on behalf of Sussex residents and supports the care market to expand in a sustainable way - We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population now and into the future.
- We will have a clear and affordable plan for the future to ensure we understand where best to invest available funds to grow discharge capacity which will meet the needs of our population now and into the future - Health and care partners will have a more proactive approach to discharge planning, minimising delays at each part of the pathway (across pathways 0 to 3) and utilising virtual wards for early supported discharge, with a more seamless interface between health and care.

6.5 The difference this will make to local people and how it will be measured:

- People will be involved in planning for their discharge from early in their inpatient stay and will be discharged without significant delay as soon as they are declared medically fit to do so into the most appropriate bed for their needs - There will be a reduction in the number of people who no longer meet the criteria to reside who are not discharged.
- People will be admitted to an inpatient bed (acute, community or mental health) in the most appropriate department for their condition, without significant delay.
- People will be discharged earlier but receive ongoing clinical oversight where required through the use of digital innovations such as remote monitoring - here will be a reduction in Length of Stay.

6.6 As an immediate priority in 2023/24, West Sussex will improve our hospital discharge model to ensure people who no longer need inpatient care can go home or in a community setting (such as a care home) to continue recovery with the aim of reducing hospital occupancy to less than 92% by the end of the year.

6.7 We will develop our integrated hospital discharge model, implement the 2023-24 hospital discharge capacity plan and deliver the improvements aligned with the Sussex-wide discharge frontrunner programme.

6.8 Our place based Discharge Transformation Programme will consolidate the efficiency of our processes. This will enable us to ensure people who no longer need acute inpatient care can go home or to a community setting (such as a community rehabilitation bed or a care home) to continue recovery. We will also ensure place based discharge pathways are aligned to national best practice and achieving maximum efficiency.

6.9 Aims include:

- A visible improvement in the hospital discharge model across West Sussex that is embedded in practice and processes together with a culture of continuous improvement.
- Reduce the number of medically fit to discharge people in our hospitals, addressing NHS causes as well as working in partnership with Local Authorities.
- Increase physical capacity and permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23.
- Reduce adult general and acute (G&A) bed occupancy to 92% or below.
- Improve patient experience by enabling people who are medically fit to discharge patient to be cared for at home or in a more appropriate setting.
- Reduce Length of Stay (LOS) in the acute and community hospitals where possible.

6.10 Under our ongoing five-year plan, we will further develop and implement efficient hospital discharge processes, supported by digital automation. We will put in place a long-term funding plan for discharge capacity. We will embed efficiency and process learning from transformation programmes into 'business as usual':

- We will have quicker and more effective discharge processes, reducing the length of the time people wait to be discharged and maximise reablement and independence after discharge.
- We will ensure that more people are able to return to their usual place of residence following discharge, increasing Home First capacity and decreasing reliance on bedded capacity.
- We will ensure discharge pathways allow for greater personalisation per individual patient need.

6.11 The measures of success for our improved discharge process to ensure people return home as appropriately as possible include:

- A reduction in the length of time between someone being ready to leave hospital and when they do.
- A reduction in overall number of people who are ready to leave hospital but cannot.
- Maximise the proportion of people who can return home after leaving hospital.

6.12 The certainty of the Additional Discharge Fund over the duration of this plan reduces the barriers encountered due to the short-term nature of the funding provided for the final months of 2022/23. It allows for the critical importance of taking time to fully engage the provider market with more confidence that this will provide more capacity and assist in redeveloping relationships with the market.

6.13 Following the national system discharge visit 31 May, we will identify further work on the system ambition for improvement and plans to address unwarranted variation in processes which will include:

- Quantifying the level of improvement ambition of the system to ensure that there is collective buy into what we are seeking to achieve.
- The variability of our D2A model and need to understand the cost to the system of the current gap to national policy.
- Our level of ambition on community bed LOS e.g., target LOS 24 days (Non MRDs)
- The very long LOS of complex MRFD MH patients and challenge on how the LAs work together to look at pan-Sussex solutions and to ensure visibility at senior leadership level.
- The current need for self-funders to remain in acute hospital whilst awaiting assessment.

6.14 For 2023/24, West Sussex health and care partners are focusing the Additional Discharge Fund on a smaller number of schemes where we have a high confidence level in our ability to deliver, reducing delayed discharges and improving outcomes, with the further development of our schemes for 2024/25 planned for Q4. Of the schemes that are workforce related which, for 2022-23, were particularly impacted by both the short-term nature of the funding and the relatively short timeline, these barriers are greatly reduced for 2023/24. Learning from 2022/23 shows that where schemes were able to be recruited to, timely discharges were supported as planned.

6.15 The Additional Discharge Fund is being targeted to specific schemes to sustain increased discharge capacity. Plans include rapid improvement and transformation through 2023/24 to increase capacity and capability to support Home First models of care and reduce reliance on bedded care capacity. Plans are developed by system partners locally at place to achieve the greatest impact in terms of reducing delayed discharges, which are overseen and agreed for the application of discharge funds at a whole system level including ICB, providers and Local Authorities.

6.16 Our learning from 2022/23 informed our capacity and demand planning with particular reference to:

- The fact that data is not necessarily held in the currencies and structure required for the submission. Therefore, where estimates have been made, we continue to make adjustments as the data is developed and understanding is enhanced.
- That some services are block and the nature of the contract does not provide us with historic activity data. We have based capacity on demand in some of these cases.
- Most services (unless bedded) have a flexible workforce to handle changes in demand across the year. Where referrals did not meet expectations, capacity flexed.

6.17 System partners have undertaken a significant amount of modelling to understand the demand and capacity across the system. Much of the data has been derived from tracking discharge hub activity and review community demand both within the NHS and local authority.

6.18 Our approach to capacity and demand planning is built upon the following assumptions:

- For demand:
    - Underpinned by Trust Discharge Sitreps for four core providers, providing analysis by pathway.
    - Demand growth 2022/23 to 2023/24 is net neutral.
    - Demand phased by month by days in month with limited adjustments for seasonal variation.
    - Pan Sussex assessment that 2% of Pathway 0 activity requires social support.
    - A limited amount of Pathway 3 activity transferred to Pathway 1, domiciliary care, in line with pan Sussex focus on Home First.
    - Analysis by 'sub pathway' (%) derived from review of patterns of referral in 2021/22 and 2022/23. This analysis will be subject to further development as part of the Discharge Front Runner Programme.
- For capacity, performance (utilisation factors), and care profiles (length of stay and resource use) derived from:

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy.)
- Reviews with service managers undertaken to validate Pathway 1 services and available data sources.

6.19 Significant demand and capacity gaps:

- Social Support: capacity exceeds demand to meet periodic fluctuations – optimisation of Pathway 0 to be addressed via pan Sussex 'Home First' strategy.
- Short term domiciliary care: capacity currently exceeds demand; the plan has been modelled to match demand as patients transferred from Pathway 3 (see note above) as part of discharge transformation plans.
- Rehabilitation at Home: capacity shown exceed demand, this allows for the number of Pathway 1 patients requiring multiple services (based on review of service use 2021/22)
- Rehabilitation in a bedded setting: demand exceeds capacity as some Pathway 2 patients will require bespoke capacity provision due to complex/End of Life Care (EOLC)/All Age Continuing Care needs. This is a focus of Discharge transformation within the Discharge Front Runner programme.
- Pathway 3 capacity meets current demand assuming the 'Home First' strategy is mobilised and supported by additional assessment capacity.

6.20 Capacity and demand planning has informed our deployment of the Additional Discharge Fund into schemes which sit alongside and complement those funded by the ICB following the end of hospital discharge national funding arrangements and level in 2022/23.

6.21 A key priority for improving discharge continues to be the Home First (HF) pathway, ensuring as many people 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 people 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.

6.22 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.

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

to people's usual place of residence. This includes the Combined Placement and Sourcing Team, Technology Enabled Care, Community Equipment, and core social care services.

6.24 During the writing of this plan, we have again reviewed the Hight Impact Change Model to ensure we continue to meet all requirements alongside the NHSE 100-day challenge requirement, and our ambitions to further improve discharge. The discharge pathways work will remain under review by West Sussex Operational Executive (OPEX) who will oversee any future actions required to improve HICM performance for changes already in place or being further developed as part of the Discharge Transformation Programme:

- Change 1: Early discharge planning: University Hospitals Sussex has a 'median hour of discharge project' underway across its sites via their continuous improvement programme.
- Change 2: Monitoring and responding to system demand and capacity: For systems monitoring patient flow, daily reporting is in place via our discharge hubs. In addition, digital systems are being reviewed by the Discharge Frontrunner Programme.
- Change 3: Multi-disciplinary working: multi-disciplinary/multi-agency discharge teams in place, including the voluntary and community sector, and transfer of care hub development in progress.
- Change 4: Home first: Home first/discharge to assess established and further optimisation work being scoped.
- Change 5: Flexible working patterns: Seven-day services in place where possible via core contracts.
- Change 6: Trusted assessment: Trusted assessors are widely in place, and this can be further developed within the improvement cycles we will undertake.
- Change 7: Engagement and choice: A focus on choice policy is being finalised which will also including a training component.
- Change 8: Improved discharge to care homes: Care home matron in place across West Sussex, enhancing health in care homes.
- Change 9: Housing and related services: The acute trusts have discharge improvement programmes underway to enhance processes including information gathered on admission, such as housing issues, so early action can be taken. Links to Housing teams is noted best practice for the development of the Transfer of Care Hubs (TOCH) and will be included in the development of the West Sussex TOCH over summer 2023.

6.25 Through our BCF-funded services, we work closely with local VCSE organisations to support everyone to be able to access:

- Clear advice on staying well.
- A range of preventative services.
- Simple, joined up care and treatment when this is needed.
- Digital services (with non-digital alternatives) that put the citizen at the heart of their own care.

- Proactive support that keeps people as well as possible, where they are vulnerable or at high risk.

6.26 In West Sussex, significant BCF funding is used to provide services which support the delivery of duties under the Care Act: In addition to our Care Act Duties scheme, our support for unpaid carers including young carers, carers who are working and older age carers are described in Section 7 below.

7 Supporting Unpaid Carers

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

7.2 Carers living in West Sussex and representative organisations supporting them have informed the refresh of our strategy for supporting carers. The Joint West Sussex Carer Strategy 2021-2026 is informed by Government legislation, national and local policies, National Institute for Excellence (NICE) Guidance and, most importantly carers views and wishes. It provides the chance to reaffirm our commitment and determination to help carers continue caring if they are willing and able, and to support their health and wellbeing by achieving outcomes they have identified matter most to them.

'We will recognise, value, involve and support the role carers play including when they are patients themselves or are our colleagues'

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

7.3 West Sussex aims to support carers to achieve the best possible outcomes for themselves and the person/s they care for. 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 to support:

- Good client/patient outcomes.
- Independence.
- Reduced visits to primary care.
- Unnecessary hospital admission/re-admission.

7.4 From the 2021 Census and new carer registration figures, there are an estimated 80,000 carers of all ages who live in West Sussex. The majority are in Arun followed by Horsham and Mid-Sussex. Nearly a third of carers are over 65 years of age. Over the past year around 450 new carers are registered in the county every month, by contracted partner Carer Support West Sussex. This is unprecedented with registrations prior to the Covid pandemic and cost of living crisis being around 250 per month.

7.5 Improving support for and the experience of carers is a key strategic priority objective of Government as set out in the National Carers Action Plan 2018-2020.

7.6 The budget for the commissioning of carer support services is circa £5m p.a. The contracts are primarily with charitable sector partners. Practice is integrated and working relationships are in place in both primary and secondary care settings.

7.7 West Sussex has actively reached and supported a greater number of carers each year. Over 32,000 carers in West Sussex are currently on our register held by Carer Support West Sussex (CSWS) a commissioned specialist provider. Carers are also encouraged to register as such with their GP Practice.

7.8 The number of registered carers has grown by 20% over the past two to three years. 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. The first Carer Support Organisation in the country to receive this award.

7.9 The Countywide Carer Information, Advice, Assessment and Support Service, provided by Carer Support West Sussex (CSWS), delivers 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.

In 2022/23:

- There are over 31,000 carers registered with us. In the last year we have had 26% year on year increase in carer registrations – 5289 new carers registered with us.
- The CSWS team worked with 10,389 unique carers by email, telephone, face-to-face, Zoom individually and in groups and via online chat functions. Almost half a staggering 49% were supporting carers with two or more conditions and with teams reporting work on at least two challenging issues in most cases. Compared to the same period last year the team has had a 34% increase in carer engagement and activities.
- CSWS' teams provided a range of locality based and specialist support and during the year worked with carers supporting: people with a long term condition (24%), people with dementia (22%); people with a mental health condition (8%); people with a physical disability (12%); people with a learning disability (4%); people with substance use issues, or addiction/recovery issues (2%); people who are frail/elderly (11%); autistic adults(3%); and under 18 with a disability or parent carers (14%).
- 7.7% of the carers we directly supported were from ethnic minority communities (compared to 4.9% in 21/22)
- Young adult carer registration was up 15% (75 new registrations) on last year.
- We have worked with 610 carers proving them with a Statutory Carer Assessment to gauge how the caring role affects their life and we completed a further 1386 light touch carers assessments were completed enabling carers to consider what would help them to support their own health and wellbeing.
- We have had 233 different carers groups/events in total, both online and face to face. The groups were attended 2,434 times, by 859 unique carers.
- We delivered over £1.3m to 3,456 carers in hardship and wellbeing funding during the year. Of those funds between July 2022 and March 2023, over £711,1000 was awarded to 1,835 carers who qualified for this grant to help with food and bills and 466 carers received a total of £232,863 in funding to

support with household items. A further 1,048 carers received a portion of £328,914 to provide support in improving overall health and wellbeing and 463 parent carers were awarded grants to the value of £102,160.

- Our Carer Benefits service helped 742 carers collectively gain £1,078,071 in additional annual benefits.
- 1,447 carers were allocated equipment to support their caring role to the value of £65,6591.51
- CSWS works in partnership with local businesses in West Sussex to offer family and friend carers in the county a range of exclusive offers and discounts through the carer discount card and 2,599 cards sent to registered carers.
- 599 carers have registered for the Carer Emergency Card which offers a contingency in case of them being unable to care.
- Our response line team have handled 28,137 incoming and outgoing calls; exchanged 28,199 emails and supported 533 online chats with carers.
- The Hospital team working in thirteen acute and community hospitals attended 460 multi-disciplinary team meetings and supported 1803 carers and a further 471 carers have been supported via the Support at Home after Hospital service. We have excellent results with 100% of carers saying they felt their health and wellbeing was supported because of this service intervention, part of the discussion is what happens next and 90% took the opportunity to discuss or access contingency planning, with access to the Carers Emergency Card and emergency respite.
- Counselling for carers – 294 carers received counselling from us.
- Carers tell us that being connected is important to them and at CSWS we reach out to carers through a range of media to maintain this connection and to keep carers informed about the available services and during the year we had 1,331 social media posts, 114 emails and 92,942 website users.

7.10 The full Carer Support West Sussex offer includes:

- Carer Response Line: Emergency Planning, Carer Emergency Contact and Discount Card, Carer Benefits Services, Onward Referrals, Signposting, Wellbeing Conversation, Carer Health and wellbeing Fund, Carer Equipment Service, and Leaflets and Enquiries.
- County Wide Services: Hospital Service – Discharge Planning, Carer Assessment and Review, Personal Budget/Direct Payments, Counselling Services, Carer Engagement, Forums and Communication, Volunteer Management, and Check-in and Chat.
- Locality Services: Signposting/Referrals to External Community/Specialist Services, Light Touch Review, Carer Coaching and Training, Locality and Specialist Information, Advice and Guidance, Ongoing In-depth Support, Emotional Support and Wellbeing, Grant Applications, and Carer Groups and Social Opportunities.

7.11 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 has advised on £2.5m in additional annual income for carers over the past 18 months.

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

- The 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 carers 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.
- 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.

7.13 The aim, in respect of the carer care pathway is to achieve the right support at the right time. 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.

7.14 The carers offer is regularly reviewed with carers of all ages and there is a 'Carer Voice Network' of around 30 carers, who have completed ' Be the Voice' training that are available for consultation and co-design purposes.

7.15 In West Sussex, a re-procurement of the main carer Advice, Information, Assessment and Support Service is planned. This will provide an opportunity to review and refresh the service specification in light of the increasing demand and changing needs of carers in West Sussex. The new arrangements to begin in April 2024.

7.16 Coproduction of a strategic Commitment to Carers pan-Sussex is planned, in order to arrive at a shared direction for the ICB, providers and partners.

7.17 The Carers' portfolio is held by the Chief Nursing Officer and progress of this agenda will be reported through the Patient Experience Committee.

7.18 This Commitment to Carers will be achieved with the support of the Sussex Carers Partnership (SCP), comprised of the three leading VCSE carers' organisations in Sussex, coming together to work on common issues for unpaid carers across the system: Carers Support West Sussex, Care for the Carers (East Sussex), The Carers Centre (Brighton & Hove)

7.19 Historically, the previous CCGs have funded the SCP to engage with carers since late 2020. This work has resulted in both valuable insight from carers, and tangible responses to recommendations outlined in engagement reports. A "Carer Engagement Forum" takes place quarterly, which includes NHS Sussex leads for Carers, the three VCSE organisations as above, and the three Local Authority Carers' Commissioners.

7.20 The forum has provided a constructive way to review insight, agree actions, oversee the development of the Carers' Maturity Matrix response/action plan and to assess future priorities/areas of work.

7.21 Carers have been identified as a health inequality "plus" population in all three Places and funding for a new Sussex Carers Health Project (SCHP) will span three years, with an overall budget of £270K per annum. Funding has been sourced and confirmed through the Health Inequalities prioritisation process.

7.22 The project will ensure that work with PCNS and with secondary care is aligned, that opportunities are progressed and learning shared. Central to this work is co-production with carers, and opportunities for carers to be involved in the development of the Sussex Lived Experience Network and associated principles and processes.

7.23 The Carers Health Project will map existing practice in primary and secondary care, identify good examples and build capacity in the primary and acute settings. Specialist workers will work with health partners to raise awareness, provide training, tools and resources that will enable GP, hospital, and related health providers to embed carer friendly approaches. Carer identification, registration and support will improve in primary and secondary care across Sussex.

7.24 The postholders will build on existing work in each Place across primary and secondary care and across local authority commissioned work, develop additional work where there are identified gaps; they will drive place-based improvements that have a consistent approach across Sussex, through a matrixed working approach.

7.25 The SCHP will support the development of key areas of work for the ICB, including Virtual Wards and ambitions for Primary Care – particularly Pillar B "Working with people and communities to improve population health and tackle health inequalities". It will embed carer awareness and support across primary and secondary care over the period of the project. The roles will work to ensure change is sustainable and learning embedded; an evaluation framework will help to support ongoing sustainability beyond the period of funding.

7.26 Over the three year period of this work, year three in particular will be forward focussed, working across both NHS and local authority partners to ensure that work can be maintained at the end of the project.

7.27 The West Sussex Better Care Fund scheme, Carers Services, supports unpaid carers by funding 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.

8 Disabled Facilities Grant (DFG) and Wider Services

8.1 There is a countywide project and 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 two countywide services: Minor Adaptations & Essential Repairs and Deep Clean and Clearance, as well as the central project support costs. The remainder of the DFG allocation within the BCF is passported straight through to the 7 districts and boroughs.

8.2 The project governance includes a dedicated part time project manager and multi-agency Working Group and Steering Group, overseen by the Chief Executives Board. The Steering Group sets the direction of the project and agree funding for the annual top slices. An annual update report is also taken to the West Sussex Leaders and Chief Executives Group.

8.3 A Memorandum of Understanding (MoU) 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.

8.4 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.

8.5 Under the West Sussex Health and Care Partnership Executive's strategic approach, 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. This 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. Health commissioners 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 enable people to remain independent in their homes.

8.6 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, which aim to be quick and non means tested, 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 (and many others) can also be used to prevent hospital admissions.

8.7 The Safe, Suitable and Warm discretionary grant is also designed to do almost anything reasonable to help disabled residents to stay independent and well at home with as little other intervention as possible.

8.8 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.

8.9 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.

8.10 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.

8.11 The local authority housing standards and grants teams, along with the Home Improvement Agency (HIA) in Adur and Worthing, 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 discretionary Moving Home Grant which provides funding to help residents to move to meet their needs more easily.

8.12 This advice also includes help and advice with property condition and repairs issues, property owner 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.

8.13 Further developments for this period include additional central project resources from the Strategic Housing Group to better join up the issues summarised above with housing. This will include work within the housing needs, homelessness and rough sleeping, development and new housing supply teams further strengthening the links between housing, health, and social care.

8.14 West Sussex has for several years made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services.

8.15 The combined cross county policy signed up to by all 7 districts and boroughs incorporates a wide range of discretionary service and grants to the value of circa £10m, including:

- The deep clean and clearance service.
- The minor adaptations and essential repairs service.
- Hospital discharge grant.
- Safe, suitable and warm grant.
- Abortive fees grant.
- Moving home grants.

8.16 All 7 districts and boroughs make full use of these discretionary grants/services which contribute to delivering on the BCF metrics. They help prevent hospital admissions, get people home more quickly from hospital/respite/discharge to assess beds, keep people safer and more independent in their homes, support reablement, and prevent falls.

9 Equality and Health Inequalities

9.1 The West Sussex partners will continue to work together guided by the council's priorities under the Equality Act, NHS equalities duties and the NHS Core20PLUS5 approach to reducing healthcare inequalities.

9.2 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.

9.3 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.

9.4 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.

9.5 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.

9.6 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 ethnically diverse backgrounds 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 brought these disparities to the fore and prompted action that

we continue in order to create lasting change, especially to remove barriers and improve access to healthcare.

9.7 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. The resulting Local Community Networks (LCN's) are delivering strong collaborative, partnerships which provide opportunities to tackle inequalities and develop effective preventative approaches responsive to local need and assets.

9.8 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.

9.9 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.

9.10 The LCNs build on previous models demonstrating the benefits of primary care working more closely with local government and the voluntary sector at district and borough, and with local communities. Working to our Shared Delivery Plan, we will address the wider determinates of health to 'build back fairer' and mitigate against further widening, based on local epidemiology and evidence of what works.

9.11 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 in need to access preventative care and support and well as supporting engagement in community level interventions to decrease isolation.

9.12 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 is to:

- Plan and deliver actions to address health inequalities with our partners across West Sussex, at place and in neighbourhoods through a combination of civic-

level interventions, service-based interventions, and community-centred interventions.

- Develop how we commission and provide services, using population health management, 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 life expectancy and to increase the quality of life.
    - 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.
    - Developing key performance indicators for addressing inequalities and supporting improved outcomes.
- 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.

9.13 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 continue develop our primary care communications, voluntary and community sector support, our local commissioned services and a clinically led training and education programme in primary care.

9.14 Reducing disparities in health care access based on ethnicity and increasing opportunities for individuals from ethnically diverse communities, including refugees and asylum seekers to be able to access primary and secondary healthcare. Health Inequalities delivery priorities for 2023-24, refreshed since the previous BCF plan, are:

- The further development of the Health Inequalities Steering Group for West Sussex Place which will support the ICS Health Inequalities Programme by providing place-based oversight of 'Health Inequalities funding stream' priority 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 ethnically diverse communities will expand across West Sussex, building on the existing work 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.

9.15 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.

9.16 The cost-of-living Crisis and the challenge for our population 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 ethnically diverse groups, or who are on low or minimum wage, older people, people with long term conditions, carers, and families.

9.17 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.

9.18 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.

9.19 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.

9.20 As we develop at place, our Better Care Fund schemes, such as Social Prescribing and Carers Support, will further align with our priorities, and many BCF schemes providing core health and care services will align to our Core20Plus 5 approach and vision of a future where people live longer in good health, where the gap in healthy life expectancy between people living in the

most and least disadvantaged communities will be reduced, and where people's experiences of using services is better. 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 ethnically diverse communities, LGBT+, LD, Older People, Carers, Asylum Seekers and Refugees and Gypsy, Roma, Traveller communities.

9.21 The West Sussex BCF schemes are subject to the requirements of the commissioning partner organisations in respect of Equality Impact Assessments. As we develop at place into 2023-24 and beyond, any review and restructuring of our BCF programme, including new schemes, will require new or refreshed Equality Impact Assessments, and will align to our ambition to reduce health inequalities.

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