East Sussex

Better Care Fund Plan

2022/23

September 2022

1. Health and Wellbeing Board: East Sussex

1.1 Bodies involved in preparing our plan

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the East Sussex Health and Care Partnership. This brings together East Sussex County Council, our new NHS Sussex Integrated Care Board, East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, and our wider system partners including primary care networks, district and borough councils, Healthwatch, the Voluntary, Community and Social Enterprise (VCSE) organisations, East Sussex Fire and Rescue Service, South East Coast Ambulance Service and education providers, registered landlords and a wide range of other public and private organisations.

In addition to the above, there are a wide range of forums where plans are discussed such as the East Sussex Housing Officers Group and Independent Providers forums.

1.2 How we involved these stakeholders?

The overall purpose of the East Sussex Health and Care Partnership is to support 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 East Sussex.

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

1. Supporting the ongoing development and implementation of a longer-term integrated local East Sussex Plan which will form part of our Sussex and Surrey Sustainable Transformation Partnership plan and respond to the NHS Long Term Plan. This will cover physical and mental health services across acute, community and primary care settings, social care, housing, and prevention.
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 we agree, and collectively tackling the issues and challenges we face as a system.

2. Executive summary

Our draft high level East Sussex Health and Wellbeing Strategy 2022 – 2026 provides the overarching framework for our joint plans and programmes of work, based on the strengths and needs of the East Sussex population. For 2022/23 we have identified a small number of priority areas where we are collectively working together to improve and transform services.

Shared priorities are where we feel we can make a real difference through working together at place (East Sussex) level within our wider Sussex Integrated Care System (ICS). They complement and align with the existing range of work our organisations will deliver locally through their annual business and operating plans and strategies, including supporting our Sussex ICS and NHS commitments.

We have reviewed our work last year to support people during the Covid-19 pandemic, as well as our progress with our programmes of work to integrate and transform care models and pathways, to ensure we can take account of our learning for 2022/23. Our priorities fall into the following the areas:

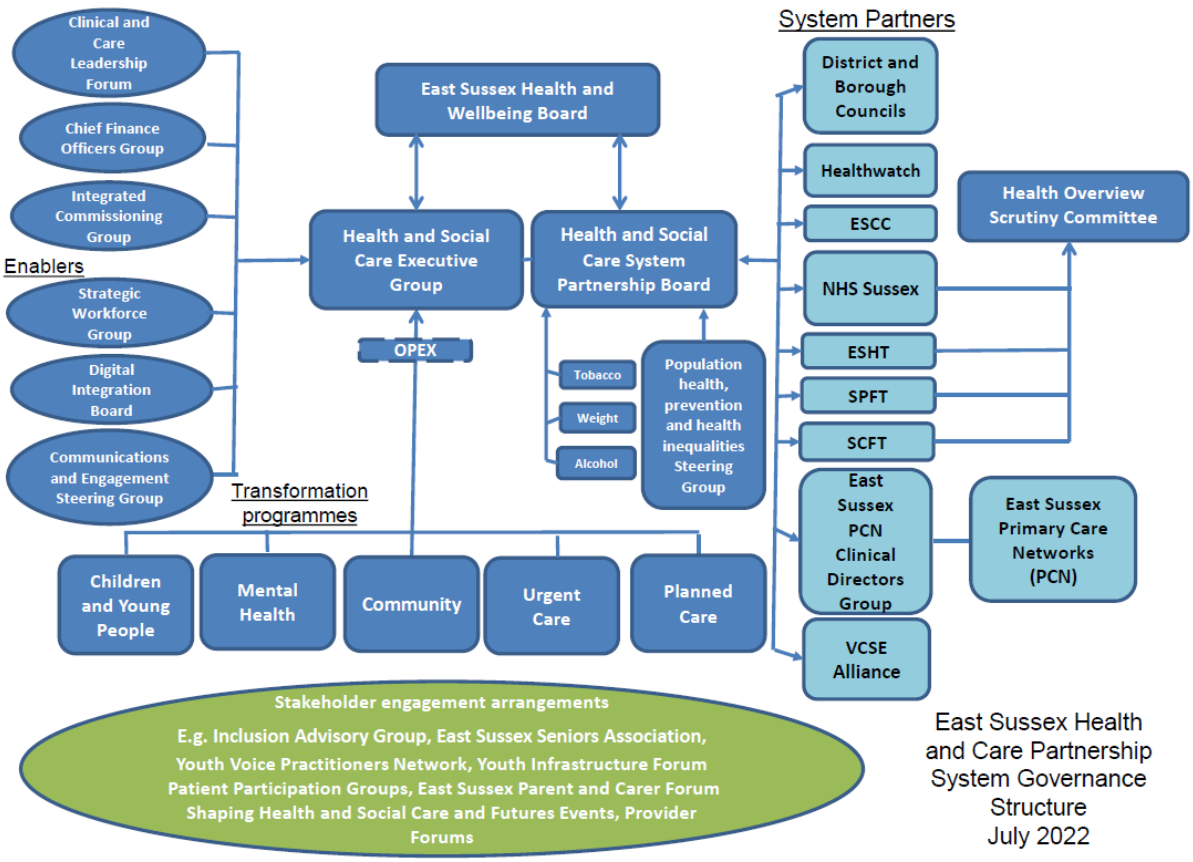
- The strategic and long-term steps we need to take to further develop our capability overall as a place-based health and care partnership within our Sussex ICS. This is aimed at increasing our ability to improve health, reduce health inequalities and deliver integrated care.
- Our shared work to integrate and transform care models and pathways in specific services and pathways. This is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services for children and young people, mental health, community, urgent care and planned care, to improve the quality, experience and sustainability of care.
- Our shared work to to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county in our population.

3. Governance

Supporting delivery of our shared priorities - our governance for the BCF plan and its implementation in East Sussex

Our organisations work together to deliver these shared priorities through our system partnership governance. Our East Sussex Health and Care Partnership reports to the East Sussex Health and Wellbeing Board, and works in the context of our Sussex Integrated Care System to strengthen how we plan, organise, commission, and deliver services together and better deliver our shared priorities for our population across the county,

Overall, in the context of our Sussex Integrated Care System, our East Sussex Health and Care Partnership is working to strengthen the way we join forces to improve the health and wellbeing of our population, the quality and experience of health and care services, and do this within the collective resources we have available.



East Sussex Health and Care Partnership System Governance Structure July 2022

4. Overall BCF plan and approach to integration

4.1 Our approach to embedding integrated, person-centred health, social care and housing services

The East Sussex Health and Well-being strategy highlights our plans for health and care services in our county. Health and wellbeing for all, however, is not just about services. It is improved by access to good jobs, transport, housing and green space as well as opportunities for lifelong learning, exercise, good nutrition and supportive networks and relationships between people and within communities. The strategy signposts to other key strategies and plans relating to these crucial 'wider determinants of health' which are led by various members of the Health and Wellbeing Board and encourages us all play our part in ensuring that everyone in the county can lead a healthy, happy, fulfilled life.

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the East Sussex Health and Care Partnership.

Our organisations are each responsible for making decisions about their resources and delivering improvements to services. The Health and Wellbeing Board's role is to oversee how well we work together to make the most of opportunities where a more joined up approach will help to improve outcomes, reduce inequalities and deliver efficiency savings that can be reinvested in service improvements.

This includes supporting the strengths and capabilities that exist in our diverse communities and neighbourhoods to make the best use of our collective resources. The strategy will also inform our shared work across Sussex, and we would expect everyone to use it when making decisions about spending money and planning services, and our joint working and collective action over the next few years in East Sussex.

4.2 Our joint priorities for 2022-23

To ensure we take account of our learning for 2022/23, our priorities fall into the following the areas:

- The strategic and long-term steps we need to take to further develop our capability overall as a place-based health and care partnership within our Sussex ICS. This is aimed at increasing our ability to improve health, reduce health inequalities and deliver integrated care.
- Our shared work to integrate and transform care models and pathways in specific services and pathways. This is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services for children and young people, mental health, community, urgent care and planned care, to improve the quality, experience and sustainability of care.
- Our shared work to to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county in our population.

Priorities for integrated health and care services

Organisations across the public, private and voluntary sector are responsible for delivering a wide range of health and care plans and services. Through our partnership work we will focus on a small number of shared priorities where we can achieve better results if we work together to offer more integrated care:

- Children and young people
- Mental health
- Community
- Urgent care
- Planned care

We work with our citizens in our number of ways to ensure the way these priorities are delivered fits with what people have told us is important about their health and care, including Healthwatch and Young Healthwatch, Youth Infrastructure Forum, Mental Health Action Group, East Sussex Seniors Association and Patient Participation Groups.

4.3 Our Approaches to joint/collaborative commissioning

Delivering the vision: Working with everyone

Our East Sussex Health and Care Partnership brings together the contributions of a range of partners to deliver this strategy, including the NHS, county, borough and district councils, the voluntary, community and social enterprise sector, and Healthwatch East Sussex.

Together, we will explore the new opportunities in the White Paper and as part of our ICS to further strengthen the way we work together on our priorities. These include more formal arrangements to plan services and share resources, aimed at increasing integrated care and better responding to the needs of our population.

In delivering the vision and our joint commissioning priorities we recognise:

- Working with people, carers, families, and communities themselves is crucial to designing services and support that works. We will continue to build on the strengths of our communities and involve people in ways that suit them through the wide range of existing arrangements and new approaches
- Healthwatch will continue to play a role at both a local and national level, ensuring that the views of the public and people of all ages who use health, care and other related public services are taken into account
- Health and care services can offer joined up high quality care that anticipates needs and intervenes as soon as possible to have a positive impact on people's day-to-day life and deliver better outcomes
- Borough and district council actions have a positive effect on public health, and an enabling role in the health of their populations and communities through innovation in service delivery

- Voluntary, community and social enterprise (VCSE) organisations in East Sussex play a key role in mobilising local social action that can bring communities together, both in times of need and more generally, as well as being a part of health and care delivery that supports people's health and wellbeing
- Family Hubs, early years settings, schools and colleges play a vital role
- Working together at a local and neighbourhood level with these and other partners will give a strong platform for the delivery of initiatives which improve health and wellbeing and services

4.4 How BCF funded services are supporting our approach to integration/ changes to the services we are commissioning through the BCF from 2022-23.

The services funded from the BCF in 21/22 will continue to be funded in 22/23 as they remain critical components of the system, by way of prevention or supporting system flow. Alongside this, additional BCF funding has been identified to support the local Hospital Discharge Programme.

All jointly funded and jointly commissioned BCF funded services contribute to delivery of the East Sussex plans for integration outlined above and support avoidance of admission to and reduced length of stay in bedded care, either directly or indirectly.

5. Implementing the BCF Policy Objectives (national condition four)

5.1 Our approach to integrating care to deliver better outcomes, how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home or return home following an episode of inpatient hospital care.

The vision of the East Sussex Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, so that everyone can have a life that is as safe, healthy, happy and fulfilling as possible.

Services are one part of the picture, and they need to be high quality and effective in empowering people to support their health and wellbeing. For health and care services, our aim is to work towards a fully integrated health and care system by 2026. By doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives. The Health and Wellbeing Strategy is designed to support the progress of the East Sussex health and care transformation programme to ensure it achieves health benefits for the people of East Sussex.

Through our work together we want to promote health and wellbeing for everyone, and make sure those who need it benefit from care and support that intervenes early, works with their strengths and supports their resilience as much as possible.

What will this look like?

- Health and wellbeing will be improved, and health inequalities reduced
- Personal and community resilience will be supported, and prevention and early intervention will be at the heart of everything we do
- The quality of care and people's experience of using services will be outstanding. Our staff will be working in a way that really makes the most of their dedication, skills and professionalism
- The cost of care will be affordable and sustainable, and secured for the next generation

Delivering the vision: Our approach

For most people their day-to-day health, care and support needs will be expressed and met locally in the place where they live. Therefore, our role as a place within our Sussex ICS is an important building block for health and care integration, and an offer to our local population to ensure that everyone can 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

In addition, our joint work will also support:

- Approaches to employment, training, procurement and volunteering activities and use of estates to allow all organisations to play a full a part in social and economic wellbeing and environmental sustainability, and

- Strong links across the full range of public and voluntary services that have an impact on people's day to day health, for example through improving local skills and employment or ensuring high quality housing and accommodation. This means working better collectively to support creating better opportunities for everyone in our community, including for example people recovering from mental ill-health or homelessness, and young people leaving care.

In delivering the vision and our priorities we will:

- Take a whole life approach from conception to death and enable links to be made throughout life, especially at key stages
- Value and build on the strengths, skills, knowledge and networks that individuals, families and communities have and can use, to overcome challenges and build positive and healthy futures
- Promote strong awareness of the impact of the wider determinants of health and wellbeing and seek to engage everyone in playing their part to ensure those determinants are as positive as possible in our county
- Increase prevention and early intervention to improve people's chances of a healthy life and to help us to manage demand for health and care services in the future
- Develop an integrated system of empowering health and care services so that people get the right care, at the right time and in the best place, whether that is in the community, primary care, secondary care or specialist care
- Reduce the inequalities that exist within and between different parts of the county and different groups of people in terms of access to services and information, advice and support. Ensuring we better record and understand the characteristics of people using our services, and tailor support

5.2 How East Sussex BCF funded services will support delivery of the objective

The East Sussex Better Care Fund Plans support the delivery of the East Sussex Health and Social care plans which address the local needs identified, the vision for integrating health and social care and to enable people to stay well, safe, and independent at home for longer whilst providing the right care in the right place at the right time.
The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2022/23 seek to support the key priorities outlined above.

To achieve these, the range of schemes listed in the planning template cover key areas of focus including:

1. Enhance prevention, personalisation and reduce health inequalities
    - Falls and Fracture Programme
    - A range of services provided by the Voluntary and community sector including support for people with sensory impairment.

2. Support for people with mental health needs by ensuring access to a full range of services including
    - Improved access to psychological therapies
    - Dementia services
3. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Health and Social Care Connect (Single point of Access)
    - Housing support and adaptations
    - Maintaining social care services
    - Community Equipment services
4. Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
    - Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
    - Crisis response
    - Hospital Intervention team based in A&E
    - Discharge to Assess - bed-based capacity
    - Domiciliary Care capacity
    - Hospital discharge support
    - 24/7 Health and Social Care Connect (Single point of Access)
5. Improve services that deliver planned care for local people
    - Diabetes self-management and pharmacy support
    - Medicines Optimisation in Care Homes
    - Dietician support to medicines management

These schemes support the delivery of all of the national BCF metrics; many of these schemes are jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.
In addition, focus has been given to developing preventative services which adopt a proactive approach to supporting people at earlier stages of care pathways.

Many of the services funded partially or wholly through the BCF in 21/22 have been continued into this year as they remain critical components of the system, either by way of prevention or supporting system flow.
In addition to these, further investment has been made into supporting the local Hospital Discharge Programme.

5.3 Our plans for supporting people to remain independent at home for longer

Our Steps to personalise care and deliver asset-based approaches

Personalised care is a key focus in East Sussex in line with the Sussex ICB priorities for 2022/23 which include:

Personalised care and support planning

- Continue to spread and scale the implementation of personalised care and support plans ensuring adherence to the quality standard criteria
- Identify a minimum of two clinical cohorts to implement PCSPs – identified priority areas for Sussex include Maternity, post covid service, digital PSCPs in EHCHs, children and young people and mental health
- Ensure workforce have access to e-learning via the personalised care institute and whole teams training where possible
- Audit quality of the personalised care and support plans including patient experience

Personal Health Budgets (PHB)

- Ensure that all Sussex residents legally entitled to a PHB are offered one. To include the right to have groups: CHCs, PWBs and S117s.
- To capture patient demographic data in relation to PHB users to ensure equity and demonstrate where efforts are being made to reduce health inequalities.
- Encourage staff groups that require additional training/support regarding Personalised Care to undertake PCI modules, eLFH module and make use of NHS Collaborative platform.
- To collect case studies from a variety of cohorts to gain feedback from service users to use as a learning tool for workforce and new PHB users.

Social Prescribing link workers

- To undertake a 'stock-take' of current place & local networks and forums to understand function/input/output to inform alignment to overall Personalised Care strategy and clear information channels.
- to ensure appropriate data process and collections are in place to support the capture of assurance and improvement metrics.
- To understand the needs of the workforce and identify opportunities to support with ongoing training and development.

In the Eastbourne, Hailsham, Seaford, Hastings and Rother areas, Southdown is jointly commissioned to provide a social prescribing service, funded via BCF called 'Community Connectors'. Southdown also provides a SMI (severe mental illness) social prescribing service called "Health & Wellbeing Coordinators" and is aimed at residents on the SMI register. In addition to the ICB/LA commissioned services, there are other services that adopt a social prescribing approach for example, Care for the Carers who are jointly commissioned via the BCF to provide a carers social prescription service specifically aimed at people with additional caring responsibilities

Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care

East Sussex is the nominated place from Sussex Health and Care Partnership to participate in the population health programme.
Some of the key achievements:

- The strategy and road map are informed by national best practice, benchmarking within the programme & system assessment against a maturity matrix that includes population health management's core capabilities 4 I's
- Governance-A system level PHM steering group established with reporting to the Population Health and Prevention Board
- A linked dataset was created and analysts from across the system have been brought together to learn PHM approaches and support PCNs when possible.
- PCNs and Place have developed MTDs, identified population groups and designed PHM interventions
- Finance professionals from across the system have come together to develop understanding of PHM approaches and support Place and PCN workstreams.

The schemes commissioned through the BCF will support these approaches through ensuring that everyone is 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

Multidisciplinary teams at place or neighbourhood level.

Working with our Primary Care Networks we will continue to enhance community services and strengthen our overall model for integrated community health and social care services. This is aimed at better supporting people with long term complex care needs and their carers in their own homes, care homes and other community settings, through embedding proactive and seamless wrap around care, including where people are approaching the end of their lives. Specific joint work includes:

Working with our Primary Care Networks and local VCSE organisations to design and develop our model for jointly planning and delivering services in our localities and neighbourhoods will help us to:

- ensure strong links between primary care, community health and social care, mental health, housing and key VCSE teams and services that support individuals with long term and complex care needs
- use more integrated data, improve and better manage the health of local populations and enable longer lives that are healthy and independent by affecting the wider determinants of health and wellbeing

5.4 Our plans for improving discharge and ensuring that people get the right care in the right place

Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

East Sussex system partners as part of the Sussex wide approach to the future of hospital discharge have agreed an emerging discharge model incorporating a range of discharge routes: from simple discharge, discharge with settling in support, discharge with Home First, discharge to a bedded setting for long term needs assessment and discharge to a bedded setting for rehabilitation.

Plans to transition the East Sussex system towards the new model of care have been developed collaboratively across partners including Opex members. They include:

- A recognition of reduced levels of system funding to hospital discharge
- Prioritisation and agreement of how reduced funding will be applied
- Improving processes and building on our existing integrated approaches across East Sussex
- Understanding of the impact on system performance of reductions in capacity
- Highlighting risks and where possible mitigations to reduce the impact.

The following principles have been developed:

- Focus on building our Home First/Crisis Response approach and reducing our existing levels DTA (former P3) bedded approach to fit within financial envelope.
- Reduction of DTA (former P3) capacity should aim to support patients across East Sussex
- Ensuring the development of our model has oversight of East Sussex Health and Care Partnership's Integrated Community Oversight Board (and other relevant strategic integration programmes in particular urgent care and planned care).

Collaborative commissioning of discharge services:

The development of the discharge model is based on an agreed set of Principles:

- Reduce DTA bedded capacitywhilst maintaining access across East Sussex, also considering service quality and opportunity to better support needs of local people
- Build Home First/Crisis Response domiciliary model alongside reduction in DTA bedded capacity
- Agreed Organisation Development across health and social care to improve consistency of approach to discharge with an emphasis on promoting independence supports implementation of future model
- Robust communications plan to be developed to support health and social care staff and patients and their families/carers
- East Sussex Strategic Workforce Group to support innovative approaches system-wide to workforce challenges that need addressing to ensure successful implementation of future discharge model.

Services funded from the BCF provide a significant contribution to these principles including D2A beds, domiciliary support for care and reablement, intermediate care provision and community equipment.

5.5 Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future

In September, the East Sussex Operational Executive (OPEX) reviewed the Hight Impact Change Model and the NHSE 100-day challenge requirement. OPEX agreed all requirements are broadly met or developing and work continues to improve discharge pathways following changes to the Hospital Discharge Programme (HDP).

The East 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 and key actions to progress this include:

- Establish future model and associated processes
- Further development of East Sussex Home First/Crisis Response Service
- Agree delivery trajectory alongside associated reduction in DTA beds (noting existing pressures in current P1 pathway).
- Identifying project resource and leadership across key organisations to deliver the project at the pace required
- Ensure programme plans with clear timeframes in place and monitored

A Capacity and Demand template has also been completed for Intermediate care services in East Sussex as part of the BCF submission for 22/23.

Actions to address key issues.

Addressing Workforce challenges

The East Sussex Strategic Workforce Group (SWG) is very aware of the current high level of vacancies across the health and care sector compounded by the national shortage in supply for many professional/registered roles that require years of training before having a positive impact on key vacancies. The current cost of living crisis is also likely to negatively affect recruitment and retaining current staff (our best source of supply), particularly for the lower paid roles with staff choosing to take other roles outside of the sector that are better paid.

SWG began to consider the impact of the rising cost of living on recruiting and retaining staff at its last meeting held on 20th July 2022 and agreed to await final confirmation of the NHS pay award before having a more detailed discussion and agreeing an approach to help support and attract staff.

In the meantime, SWG members, in consultation with independent, voluntary and hospice stakeholder organisations have agreed, through a collaborative approach, to focus on the following initiatives

- Creating an East Sussex Health and Care virtual careers hub
- Mobility – passporting across the system
- New to care apprenticeships - working as one system
- Maximising what we are already doing – recruitment pilots etc.

- Recruitment of 1.5 FTE Project Managers and 1 FTE trainer in Adult Social Care training team to promote the sector and maximise community opportunities
- Working in partnership with NHS Sussex and Armed Forces Network to establish on-going recruitment campaign for veterans, reservists, cadets
- Engaging with 6th form colleges to attract students to ASC through placements and training
- Pilot programme with DWP to offer 'try before you apply' placements for over 50s on Universal Credit
- Attending numerous careers/recruitment fairs across the County
- Working closely with partners to generate new ideas and undertake strategic planning
- Developing East Sussex Recruitment Hub to facilitate access to jobs across the County
- Funding to support independent sector home care agencies with overseas recruitment, resulting in 100 additional carers working in East Sussex by June 2022

Addressing cost of living crisis

Below outlines two initiatives which demonstrate how we are supporting vulnerable people and disadvantaged communities:

Free, confidential support and advice continues to be available through our BCF funded East Sussex Welfare Benefits Service for people who are facing financial difficulty, struggling to pay bills or concerned about growing debt. In Q1 22/23, the project realised £1,504,724 annualised benefit income for residents. Of those people:

- 4,747 household members benefitted from benefits and debt advice
- 511 people received face to face casework support
- 80% of respondents reported improved mental wellbeing
- 75% of callers and 59% of casework clients lived in the most deprived wards
- 84% of callers and 62% of casework clients had long term health conditions
- 490 older people received advice to support their independence
- 485 families with children received benefits and debt advice

Additionally in our most deprived communities, health and wellbeing community hubs have a vital role in providing advice and support to local people. For example, in North-East Hastings during Q1 22/23, 878 adults and children received an emergency food hamper with 5 new households receiving a hamper each week. Further analysis shows that 63% of those in receipt of a food hamper are on benefits, 12% considered themselves vulnerable and 9% were on low wages causing the need of additional support.

6. Supporting unpaid carers.

How our BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

6.1 Carers Centre provided by Care for the Carers to:

- Raise awareness with service providers & within communities to identify & reach carers
- Information & advice
- Targeted support both to assist with accessing appropriate support for carers & cared for and for carers' own emotional and physical wellbeing
- Act as "one stop shop" with referral pathways to a range of carers' services
- Provide a range of universal services provided directly by Care for the Carers and commissioned through small grants*
- Provide peer support, carer engagement, wellbeing support and training, Carers Card (contingency planning and discounts)
- Targeted services including one to one casework and emotional support, counselling, Health Care Appointments Respite Grant,
- Targeted support for carers of people with severe mental illness
- Working with Primary Care practices in the most deprived areas of Hastings to reach carers with the most complex needs/caring roles (funded separately through Health Inequalities monies)
- Undertaking carers' reviews on behalf of ASC

6.2 Outcomes

- Carers identified early in caring role
- Reduction in carers reaching crisis point
- Carers referred to Single Access Point
- Carers recognised as expert partners in care through the health and social care systems
- Increase in carer friendly communities
- Identification of carers from communities that are hard to engage, those who have additional vulnerabilities and those at key transition points
- Carers recognise themselves as carers and are enabled to access the information, advice and support that they need
- Carers have access to information and advice in a range of formats including by phone and online
- Carers are signposted/referred on and/or provided with appropriate support/services
- Carers are supported and enabled to find their own solutions without the need for ongoing support
- Single referral route for both carer and professional referrals
- Carers can access peer support e.g. through groups or online fora
- Carers have access to engagement opportunities such as consultation
- Carers have access to health and wellbeing opportunities
- Carers can access universal services which reduce the need for access to targeted services

- Carers can access emotional and practical support including face to face, counselling, short-term and crisis interventions that enable carers to look after their own health and wellbeing and sustain their caring role
- Carers can access training, e.g. condition specific, building resilience, stress management and digital inclusion that will inform their caring role and enable them to care without negatively impacting on their own health and wellbeing
- Services are inclusive of carers caring at end of life and experiencing bereavement; carers from communities that are hard to engage; those who have additional vulnerabilities and those at key transition points

6.3 Care Act services

- Carers Personal Budgets – direct payments to carers to meet Care Act eligible outcomes following a carers assessment or review
- Carers Reviews Pilot – carers' reviews allocated to Care for the Carer to undertake on behalf of ASC
- Funded Respite for ASC clients to give carers a break
- Volunteer Respite services - short home-based breaks (sitting service) where the cared for person is at risk if left alone
- Carers Break and Engagement Service – undertake carers assessments and reviews for carers of people living with dementia in addition to the NHS funded Dementia Support Service

6.4 Small Grants

A range of grant funded services including:

- Carer support at all 3 hospices
- Outreach to identify & support BAME carers in Hastings & Eastbourne
- Dementia training
- Digital inclusion
- Short breaks – lunch/supper clubs, creative & social activities, cookery
- Targeted support – Motor Neurone Disease, parent carers of young people with SEND (16-25)
- WRAP (Wellness Recovery Action Planning)

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Whilst the DFG funding is passed down in its entirety, deployment of the DFG funding within the BCF is overseen by the East Sussex Housing Officers group with representation from East Sussex County Council and the Housing departments within local District and Borough Councils as well as health commissioners and wider housing sector partners. This group provides a countywide strategic approach to housing and support issues and oversee to ensure effective use of the funding available, including use of adaptations to support independent living and the establishment of Occupational Therapy (OT) teams aligned to each of the Housing departments.

The Housing OT service enables an integrated approach to improved housing solutions and home adaptations to East Sussex residents. It is aligned to the District and Borough Councils' Housing departments to promote the prevention of ill health (falls), avoidable hospital admissions, improve hospital discharges, reduce residential / nursing home admissions and to promote quality of life and wellbeing through major and minor home adaptations.

This has enabled the D&Bs to provide home adaptations at the earliest point of contact, ensure that local needs are appropriately met, and a more seamless service is experienced by people with disabilities in respect of their housing and other social care needs.

In 21/22, 1.381 referrals were received by the Housing OT service. Referrals were for a mixture of adaptations and housing needs work, referred via ASC and also directly from the NHS to support complex hospital discharge.

The service has developed the use of 'standard recommendations' for level access showers and have piloted the use of this in Rother where it has worked well, this is for simple straightforward cases where the layout of the properties are known (ie some sheltered housing units), in some cases we have been able to use information from clinic along with a telephone assessment to complete recommendations. This has helped to speed up processes to enable adaptations to be installed more quickly.

With regards to housing needs, the Housing OTs service complete reports for Housing needs teams outlining where disability is significantly impacting on the current housing situation and providing information around features required within a property if being rehoused. The service will also consider properties that are being offered to a client to ensure they either have the required level of accessibility or are able to be adapted to make them accessible.

Recent feedback from Hospital OT team lead "*having the links with the housing OTs has been invaluable to support with complex discharges where housing issues are preventing discharge, the knowledge the housing OTs have and their ability to provide timely input has supported the hospital OTs*."

The service is also looking at ways to measure the impact of adaptations on individuals' quality of life, safety, independence and wellbeing through a pre and post adaptations survey.

Other examples of local innovation:

Wealden District Council:

The discretionary policy has been reviewed to provide additional assistance for Dementia, hardship and feasibility cases and support the continuation of our successful assistance in shared equity loans and top ups.

Wealden's shared equity loans, highlighted by Parity Trust in their recent newsletter and highlighted as best practice by Foundations, allows housing departments to offer an equity loan to individuals and families whose current home is unadaptable for their disability requirements, allowing them to purchase a home locally which is either adapted or adaptable to suit the needs of family members residing in it. This has provided help to help some of the most trapped vulnerable families.

Wealden are about to adapt 2 temporary accommodation units. One for ambulant disabled and one as a fully accessible wheelchair unit which will provide more much needed accessible temporary accommodation.

Following a disappointing take up of the new Dementia assistance Wealden are looking to review the scheme this year to adopt best practice coming out from national guidance and foundations best practice.

Hastings Borough Council:

Wider discretionary policies are currently being developed to address health inequalities and deprivation more effectively and to react to the realities of the current housing situation.

Where adaptable property is scare, particularly in terms of accessibility for wheelchairs etc, proposals include making adaptations to temporary accommodation so those waiting on the housing register for suitable properties are not left in unsuitable or insufficient housing until a more suitable property is found

The barriers to people getting adaptations they need are also being considered with a view to utilising DFG funding as far as is possible. Examples include widening the discretionary policy to cover circumstances such as:

- hospital discharge assistance – e.g., for cleaning, decluttering so they can come home
- alternative accommodation (in certain circumstances) – whilst DFG work is being carried out
- urgent home repairs to reduce risk of accidents
- incentives to bring empty homes into use to there is more availability of properties with adaptations provided
- adaptation of a second property where a child's parents are separated

8. Equality and health inequalities

Our priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services.

We have groups of people, communities and individuals living in East Sussex who experience worse health than other people. These inequalities are caused by a number of factors, including a person's income, their housing, education and employment status. These differences are avoidable and need more of a focus to tackle.

Some people find it hard to get the care they need due to physical, sensory and mental health issues, the language they speak, the attitudes of other people and difficulties in getting and understanding information. We want everyone to have the same opportunities to lead a healthy life, no matter where they live or who they are.

The Covid-19 pandemic also further highlighted how a combination of structural inequalities in our society (for example income and housing), and inequalities experienced due to ethnic background and other characteristics led to increased risks for some groups in our population.

We want to reduce health inequalities for our population. This will be measured by inequality in healthy life expectancy at birth and will require us to work differently at how resources are used, how we assess the impact of the decisions we make and look at new ways in which everyone can have equal access to appropriate services. This includes identifying where some groups may require more intensive support and additional help to access services. Health and care also needs to be delivered with an awareness of the differences between groups and within our population, and tailored to individual's strengths and potential vulnerabilities. Every opportunity will be explored to make sure we improve our ability to do this.

8.1 Changes from previous BCF plan

We will build on our existing progress to empower people to stay healthy and well for as long as possible, reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county. We will do this by working with all the services that influence health, like housing, employment and leisure as we believe that collectively our organisations can make a real difference to our population's economic and social wellbeing

8.2 How these inequalities are being addressed through the BCF plan and BCF funded services

We are monitoring our progress with delivery of our priorities across the four areas below to make sure we are having the most impact:

- Addressing the physiological causes of ill health to prevent premature death and the overall prevalence of disease including specific action on early cancer diagnosis, chronic respiratory disease, hypertension case finding to minimise risks of heart attacks and strokes, continuity of maternity care and annual health checks for people living with serious mental illness and learning disabilities

- Supporting individuals and populations to adopt healthy behaviours, including healthy weight, alcohol harm reduction and tobacco control
- Addressing 'psychosocial' factors and the wider determinants of health in our communities, including the social and economic wellbeing of our population
- Further developing our capability as a system, including through locality and neighbourhood working and a 'Population Health Management' approach. This is a way of working supported by data to help frontline teams understand current health and care needs, and what factors are driving poor outcomes in different population groups, resulting in more proactive models of care which will improve health and wellbeing today as well as in future years.

8.3 Any actions moving forward that can contribute to reducing these differences in outcomes

The Core20Plus5 approach is designed by NHS England to support Integrated Care Systems to drive targeted action in health inequalities improvement, particularly focussing in reducing healthcare inequalities.

Sussex ICS have asked each Place to identify two priority groups for their populations to focus on in 2022/23, and to set out high level plans for reducing the health inequalities (poorer health access, experience or outcomes) experienced by these groups.

Initial discussions about choice of "Plus" groups for East Sussex took place at the meetings of the East Sussex Population Health, Prevention and Inequalities Working Group and the following criteria were used to review potential plus groups for East Sussex:

1) Do we understand the unmet health access, experience and outcomes of the groups?

2) Is there already a programme in place to deliver improvements for this group?

3) Is there capacity to develop and deliver a plan of action for this group?

After consideration of several different protected characteristics and groups with poorer than expected outcomes, it was agreed East Sussex would focus on carers and LGBTQ+.

Outline plans to improve access, experience and/or outcomes to healthcare for LGBTQ+ groups were developed based on the recommendations of the recent needs assessment, and high level proposals for carers were developed following discussions between public health, the carers lead commissioner, children's equality lead and Care for the Carers. These were approved at the Population Health, Prevention and Health Inequalities Working Group in May 2022. The funding for carers services within the BCF plans will support this work.

One overarching recommendation is that the East Sussex Health and Care system prioritises the improvement recording and monitoring of protected characteristics. Although Carers are not a protected group under legislation, it is recommended that within the East Sussex health and care system that they are treated in this way. In terms of making change – there are two approaches – top down- SROs for Health inequalities champion the importance of data

recording and monitoring within their organisation; and practically - to link up with the ICS programme to improve ethnicity recording and include LGBTQ+ and carers at the same time when reviewing data systems and considering staff training.