Better Care Fund Narrative Plan

2023-2025

East Sussex Health & Wellbeing Board

June 2023

Contents

1. Stakeholder Engagement

In East Sussex, an integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in developing all our local plans which align to the Better Care Fund (BCF) plans. At a local level this integration is managed through the East Sussex Health and Care Partnership which brings together:

East Sussex County Council (ESCC)
NHS Sussex Integrated Care Board (ICB)
East Sussex Healthcare NHS Trust (ESHT)
Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership NHS Foundation Trust (SPFT)
Primary Care Networks (PCNs)
District and Borough Councils (including Housing)
Healthwatch
Voluntary, Community and Social Enterprise (VCSE) Alliance
East Sussex Fire and Rescue Service
South East Coast Ambulance Service
Education Providers, Registered Landlords, and a wide range of public and private organisations.

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 5-year integrated local East 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.

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. This includes Healthwatch and Young Healthwatch, Youth Infrastructure Forum, the Mental Health Action Group, East Sussex Seniors Association, and patient participation groups. Meetings have also been held with partners to discuss specific aspects of the East Sussex BCF plans and ensure a collaborative and cohesive approach to their development.

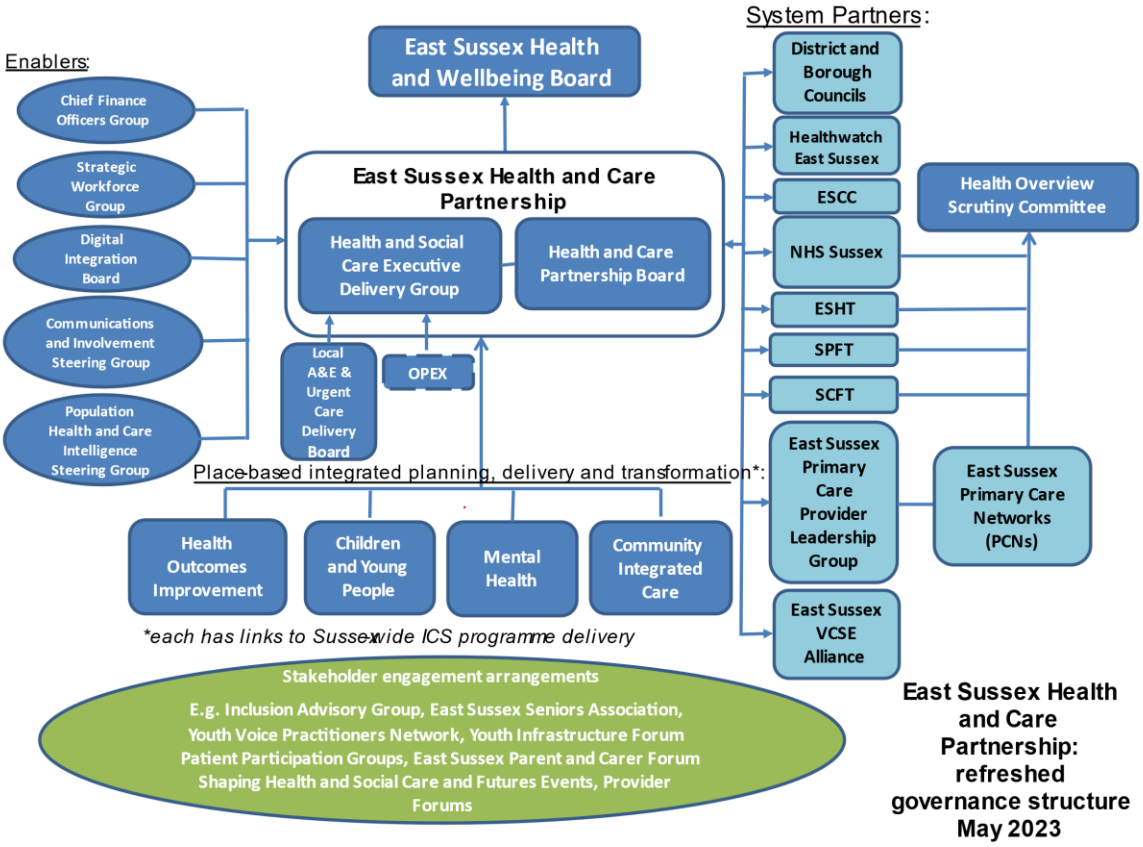
In addition to approval of the plan there is ongoing and regular stakeholder engagement via established forums. For example, with our providers in respect of discharge planning and

monitoring, system performance, capacity and demand planning, and at individual scheme level with NHS providers, social care providers, VCSE providers, and housing authorities.

2. Governance

East Sussex is one of three places in our Sussex ICS (alongside West Sussex and Brighton and Hove) that are working together to deliver our shared priorities through a shared plan. The East Sussex Health and Wellbeing Strategy provides an overall framework for our partnership work in East Sussex, and with the public, aimed at improving the health and wellbeing of local people and transforming the way we provide health and care.

Our established place-based system partnership governance has evolved over four years since its inception in 2019. During that time core membership across the range of system partners has remained relatively stable, and programme governance has been used to support delivery of shared priorities originally set out in our East Sussex Health and Social Care Plan (March 2020), which brought together County Council priorities and NHS Long Term Plan commitments.



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

- Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy 2022-2027

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council

- 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 East Sussex ambitions and actions.

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. East 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 BCF.

3. Executive summary

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 has the opportunity to have a life that is as safe, healthy, happy, and fulfilling as possible.
For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

Priorities for 2023-25

There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

- improving health and reducing health inequalities
- improved access to local services
- bringing together health and social care
- urgent and emergency care.

The Better Care Fund will continue to play a significant role in the driving improvement in all of these areas through the integration and pooling of resources to support delivery of our shared priorities.

Key changes since previous BCF plan.

The Sussex-wide Integrated Care Strategy ***Improving Lives Together*** was launched late in 2022/23 providing a strategic approach for ensuring the Better Care Fund across all parts of Sussex is focused on delivery of the key priority delivery areas via a Shared Delivery Plan.

To support these delivery areas, the BCF funded schemes are carried forward from the previous year with the following additions:

- Discharge Fund: Local Authority (LA) Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Quarter 4 (January – March) 2022/23.
- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

4. National Condition 1: BCF plan and approach to integration

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 has the opportunity to have a life that is as safe, healthy, happy and fulfilling as possible.

For health and care services, our aim is to work towards a fully integrated health and care system and by doing this we will ensure people receive high quality, coordinated care, enabling them to live good lives.

East Sussex joint priorities for 2023-25

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.
There are common themes throughout all the East Sussex priorities which will be a part of everything we deliver over the next three to five years. These are:

1. Improving health and reducing health inequalities by building 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.
2. Improved access to local services by improving the range of services available in the community.
3. Bringing together health and social care by removing barriers between our health and social care teams to support very frail and vulnerable people with long-term complex care needs and conditions.
4. Urgent and emergency care by making sure people get seen in the right place, at the right time by the right healthcare professional.

All the schemes within our BCF plans contribute to delivering these priorities and themes, and there are a range of wider commissioning and delivery plans which cover specific services and objectives in more detail.

The East Sussex approaches to joint/collaborative commissioning.

Our East Sussex Health and Care Partnership brings together the contributions of a range of partners to deliver this strategy, including the NHS, county, district, and borough councils, the voluntary, community and social enterprise sector, and Healthwatch East Sussex.
Together, we continue to explore the opportunities joining up care for people, places and populations and as part of our ICS to further strengthen collaboration on our priorities. These include more formal arrangements to plan services and share resources such as within the Better Care Fund, aimed at increasing integrated care and responding better to the needs of our population.

In delivering the vision and our priorities we recognise that:

- Working with people, carers, families, and communities is crucial to designing services and support that works. We will continue to build on the strengths of our communities, involving people in ways that suit them through a 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.
- District and borough 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 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.
- Working together at a local and neighbourhood level with our partners will give a strong platform to deliver initiatives which improve health, wellbeing and services.

We continue to develop how we jointly commission and provide services, based on our knowledge of population's health and care needs and 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.

How BCF funded services are supporting our approach to continued integration of health and social care.

The services funded from the BCF in 2022/23 will continue to be funded for the next 2 years as they remain critical components of the system, by way of prevention or supporting system flow. 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.

Alongside this, the Discharge Funding will be used to ensure people are transferred to an appropriate setting after an acute episode in order to maximise their outcomes and opportunities to return to independent living.

5. National Condition 2: Enabling people to stay well, safe, and independent at home for longer.

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.

Our steps to personalise care and deliver asset-based approaches.

The focus of our shared work on health and care services is aimed at increasing prevention and early intervention and delivering personalised, integrated care across services.

Through the BCF and wider programmes, we will continue to enhance community services and strengthen our overall model for integrated community health and social care services in our neighbourhoods and localities. Working with our Primary Care Networks and local VCSE organisations we will use information about local populations to better understand and target the needs and risks of particular groups, aimed at:

- increasing opportunities for proactive care and prevention across the wide range of local services that can improve health, wellbeing, and care, and reduce health inequalities in our communities.
- 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 wraparound care, including when people are at the end of their lives.
- further developing Trusted Assessor roles, rapid crisis response and support with discharges from hospital, as well as exploring ways to build more integrated leadership and roles to deliver better coordinated care.

A project called ‘Universal Healthcare’ is already underway in Hastings with a number of community engagement workshops having taken place to understand the needs of local people and help shape how they can be better supported in the long term. We intend to be able to start new ways of working and this is a good example of the way we want to work with our communities in future.

Our approaches to population health management, and proactive care, and how our schemes commissioned through the BCF support these approaches.

Our East Sussex Health and Care Partnership has a set of shared priorities drawn from the East Sussex HWB Strategy which are set out as four programmes all aimed at delivering improved health, care and wellbeing and reduced health inequalities based on the needs of our population. The overall focus of our shared work on health and care services is aimed at changing the way we make access to services and support available for people locally, increasing prevention and early intervention and delivering personalised, integrated care.

Population health management, prevention and health Inequalities are key areas of focus within the East Sussex delivery plan. Our shared priorities are to:

- Address the physiological causes of ill health to prevent premature death and the overall prevalence of disease.
- Support individuals and populations to adopt healthy behaviours.
- Address psychosocial factors and the wider determinants of health in our communities.
- Strengthen our capability as a system.

Through services funded via the BCF, we work closely with local VCSE organisations to 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.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

Our development of multidisciplinary teams at place or neighbourhood level

In East Sussex, we will take the opportunity to expand and enhance our model for the way all our teams can work together in communities and neighbourhoods and removing the barriers between our organisations to enable them to do this.

- Use a specific site to test and develop a ‘proof of concept’ model:
- Test and develop our approach together; the suggestion is to focus on Hastings initially, followed by further phases of similar activity to roll the model out across the county.
- Build on the existing related services and projects.
- Build on our original target operating model for community services to ensure primary care, mental health and services that impact on the wider determinants of health and wellbeing are fully a part of the model.

Our work to support unpaid carers and deliver housing adaptations on delivering this objective.

A wide range of services to support unpaid carers are funded through the BCF including:

- ASC undertakes Carers assessments and reviews with allocation of a Carers Personal Budget as required to meet identified eligible needs.
- Carers reviews also offered by Care for the Carers – pilot project.
- Young Carers assessments/reviews undertaken by commissioned young carers provider.
- Carers assessments/reviews for carers of people living with dementia included in Dementia Support Service
- Carer respite allocated as a service to the cared for person.

- East Sussex Carers Centre offers information, advice, support, peer support groups, engagement opportunities, counselling, Carers Card (emergency plan, discounts), respite funding for healthcare appointments and training.
- Targeted support for carers of people with severe mental illness
- Carer identification and targeted support through primary care in Hastings and the Havens
- Short breaks provided through a volunteer respite service.
- Carer crisis service - short term interventions to meet agreed outcomes.
- Range of services provided through small grants – dementia training, cookery & arts activities, targeted support for BAME carers, carer support in hospices, digital support, lunch & supper clubs.
- Telephone befriending

Adapting the home can increase the usability of the home environment and enable people to maintain their independence for as long as possible. This has been shown to reduce the risk of falls and other accidents, relieve pressures on accident and emergency services, speed hospital discharge and reduce the need for residential care. Provision of home adaptations is likely to alleviate pressure on unpaid carers and enable disabled people to assess the wider community.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified Occupational Therapy (OT) staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple Disabled Facilities Grant (DFG) adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers

assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

Innovative applications of Housing Assistance Policies across the District and Borough Councils in East Sussex have enabled a larger number of residents to access home adaptations via support such as:

- Flexible application of financial means testing
- Addition of adaptations outside of the mandatory DFG framework (ie Dementia assistance grants to support people with dementia to retain independence at home for longer)
- Additional funding over the mandatory £30,000 mandatory limit
- Identifying high risk situations – such as falls accessing stairs and speeding up processes for accessing solutions to reduce risks.
- Hospital discharge grants including assistance with deep clean/decluttering.
- Support to relocate where existing property is not suitable for adaptations.

Our rationale for our estimates of demand and capacity for intermediate care to support people in the community.

Learning from 2022-23

- There is variable access to Pathway 1 services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) are complex and there is a need to simplify the existing pathway.
- These will be forward as part of Hospital Discharge transformation and Discharge Front Runner programme.

Our approach

Demand 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.

Capacity Assumptions

- 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.

Significant Demand and Capacity Gaps

- Rehabilitation in a bedded setting: As for Hospital Discharge, demand exceeds capacity, primarily in the south and east of the County. This is a focus of Discharge transformation and use of discharge capacity.

Further work to refine the data is being undertaken as part of the Discharge Front Runner programme, this will include data for Mental Health pathways.

How East Sussex HWB is using the Better Care Fund to Enable people to stay well, safe, and independent at home for longer.

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023/25 seek to support people to stay well safe and independent at home for longer through:

1. Enhanced prevention, personalisation and reducing health inequalities.
    - Falls and Fracture Prevention Programme as part of the ESHT community programme.
    - A range of services provided by the Voluntary, Community and Social Enterprise sector.

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 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 BCF schemes support the delivery of the BCF metrics with many of these schemes being 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.

Although attribution at 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: Provide the right care in the right place at the right time.

Our ongoing arrangements to embed a Home First approach.

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. This will include:

- Implementing a strategic approach to our enhanced Discharge to Assess (D2A) services to improve outcomes for patients, including linking this to other services such as rehabilitation and reablement and pharmacy support.
- Reviewing our proposed integrated urgent community response model across acute, community health and social care. This will support people to avoid going into hospital where there is a better alternative service and enable them to get home quickly when they are ready to leave hospital.
- Identifying and implementing Trusted Assessor opportunities, for example NHS staff being able to commission simple social care packages and telecare.
- Supporting the local implementation of 'virtual wards' to increase proactive care coordination at home for very frail people with complex care needs.

Our approach to improving discharge.

Our discharge improvement and transformation programme is being delivered within our SDP Discharge and Social Care Board, supported by our participation in the national Discharge Front Runner programme.

The selection of Sussex as a Discharge Front Runner will enable the existing initiatives to be built on and taken further to make greater improvements for local people.

Discharge Front Runners will involve local health and social care partners being supported to work together to rapidly find innovative solutions and new approaches, which have the potential to make a substantial difference to improving discharge across the country. They will specifically look at how workforce, data and digital, and intermediate care, can be better used to speed up discharges.

As part of the Discharge Front Runner programme our system is undertaking a comprehensive hospital discharge patient needs analysis, building on the work completed last year, which will be the underlying evidence base for our transition and future models.

Place-based initiatives are enabled through our system wide prioritised approach to developing the following to underpin our agreed model:

- A joint workforce planning framework across health and social care including the care provider market.

- Widen our scope of digital innovations.
- Business intelligence management tools: working towards a live tracking system to support demand modelling, performance improvement and operational oversight.
- Move to more innovative funding approaches as part of the total economic model to achieve more sustainable contracting, delivery, and better value for money.
- Delivery of a programme of discharge improvement at system, place, and provider level.

What we achieved last Winter

- Co-ordinated the identification and delivery of place-based schemes and associated prioritisation for capacity investment in relation to the £300m National Adult Social Care Fund and £200m Discharge Fund.

- Rolled out 100 Day Challenge High Impact Actions to Community and Mental Health providers building upon internal discharge improvement work undertaken within our community and mental health providers.

- Improved system visibility of data with the development of a system discharge dashboard covering a wide range of key performance indicators.

- Developed a new system Choice Policy based upon best practice, which has been agreed by all stakeholders and is being implemented in Q1 of 2023/24 supported by the provision of training for staff involved in discharge.

- Completed a review of the three Sussex discharge hubs against nationally published best practice guidance to inform the Transfer of Care Hub development for 2023/24

- Maintained the number of Medically Ready for Discharge (MRDs) at Quarter 1 (April–June) 2022/23 baseline levels over the Winter period with improvements in East Sussex.

- In Q4 of 2022/23 delivered an improvement in weekend discharges across the acute hospital sites.

What we learnt over Winter

- That there is a need to consider the cultural changes required to deliver and embed systemic improvements and to ensure that there is sufficient change capacity and capability in place to support implementation.

- That the short notice, non-recurrent nature of additional discharge funding made available for Winter resulted in the purchase of additional capacity, limited to the care market's ability to respond, which could not always be fully aligned to the strategic needs of the system, e.g. Interim care home beds for short-term placements with constrained onward care capacity and stretched assessment resources.

- It is important to ensure consistency around data and flow so performance management and strategic direction setting can be more closely aligned.

- It was identified that there is a significant opportunity to utilise Personal Health Budgets going forward learning from the use of Personal Health Grants over the Winter Period.

Feedback from the national system discharge visit to East Sussex on 31st May 2023.

We will receive a letter setting out the areas that are recommended to be addressed. This is expected to include further work on the system ambition for improvement and plans to address unwarranted variation in processes. This will be reflected in further development of this plan and overseen by the Discharge Front Runner Programme, linking back to local BCF governance.

Additional discharge funding: How we will use the to deliver investment in social care and community capacity to support discharge and free up beds.

A number of schemes have been agreed following review of the schemes funded from the additional discharge funding in Q4 2022/23 where there is confidence they can be fully utilised in line with the capacity and demand modelling for 2023/24. These include:

- Home care: additional block hours to support hospital discharge.
- Weekend Discharge Team: additional capacity to facilitate hospital discharge at weekends.
- High Intensity Users/Mental Health Discharge Co-ordinators
- Additional Adult Social Care assessment capacity
- Personal Health Grants: small grants to support low level hospital discharges.
- Additional D2A Beds
- Assisted Discharge Home: additional capacity for this service provided by the British Red Cross to support low level hospital discharges.

Early plans for 2024/25 will continue to ensure the required capacity is available to support Home First pathways however this will be subject to review of the demand for and efficacy of each later in 2023/24. These plans also include therapy support to the additional beds to maximise people's independence and opportunities to return home.

Our rationale for our estimates of demand and capacity for intermediate care to support discharge from hospital.

Learning from 2022/23

- There is variable access to Pathway 1 Home First Urgent Community Response (UCR) services due to geographical areas of challenge in respect of the availability of onward care capacity.
- The current processes for referral to Discharge to Assess (D2A) pathways are complex and there is a need to simplify the existing pathway.
- Assessment capacity to meet all demands including timely assessments to support discharge was a challenge over the winter period.
- Complex cases remain a key issue, where clients' clinical needs are high requiring specialist input from a range of professionals and services.
- The care market faces a continuing challenge to recruit and retain sufficient staff to meet demand both in the community and for hospital discharge.
- Challenges in the availability of onward supported accommodation capacity for adult, older people, dementia, and rehab patients with mental health related conditions.

What we have been doing

- December 2022 restart of length of stay reviews for longest waits.
- Zero tolerance to bedding of same day emergency care areas from December 2023
- Gap analysis on processes and understanding of discharge and pathways at ward level January to March 2023
- April 2023 move to protect clinical decision unit for use only by the Emergency department.
- April 2023 Created a new Discharge Lounge at Eastbourne DGH and prevented bedding of lounge at Conquest Hospital.
- May 2023 Full audit of all patients not meeting criteria to reside (NCTR) on both acute sites with support of clinical team from the national Emergency Care Intensive Support Team.
- Development of full back to basics for discharge training programme – commenced delivery to Train the Trainer for all wards May to June 2023
- Revision of on call training support to support on call teams with best practice for patient flow.
- Review of oversight and management arrangements for discharge – new discharge lead May 2023 and improvement plan development April onwards
- Joint work between Trust managed UCR and ASC to allow patients to be supported home prior to ASC picking up so reducing length of stay.

Our Approach

East Sussex system partners have undertaken a significant amount of modelling to understand the demand and capacity for different parts of the system. Much of the data has been derived from tracking discharge hub activity and reviewing unmet community demand both within the NHS and local authority.

Demand Assumptions

- Underpinned by Trust Discharge Sitreps for 2022/23 for four core providers, providing analysis by Pathway.
- Growth 2022/23 to 2023/24: net neutral
- 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 agreed focus on ‘Home First’ and evidence from East Sussex service leads.
- Analysis by ‘sub pathway’ (%) derived from review of patterns of referral 2021/22 and 2022/23; this analysis will be subject to further development as part of the Discharge Front Runner Programme

Capacity Assumptions

Performance (Utilisation factors) and Care Profiles (length of stay and resource use) derived from:

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 services (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy)

- Reviews with service managers were also undertaken to validate Pathway 1 services and available data sources.

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 but is also reflective of known shortfall in the system evidenced by waiting lists for these facilities together with unmet demand from the community. 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.

How East Sussex HWB is using the Better Care Fund to provide 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 2023-25 seek to provide the right care in the right place at the right time through:

1. Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive 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

2. 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.
    - Urgent Community Response services
    - Hospital Intervention team based in A&E
    - Discharge to Assess - bed-based capacity.

- Domiciliary Care capacity
- Hospital discharge support provided by the Red Cross.
- 24/7 Health and Social Care Connect (Single point of Access)

These BCF schemes support the delivery of the BCF metrics with many of these schemes being 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.

A commitment from operational teams to collaborate and improve services by taking a whole system approach, reviewing pathways and processes to identify barriers and improve patient journeys, examples of this include:

- Developing direct referral pathways from hospital discharge teams into housing adaptations teams (on occasions using the District and Boroughs powers under their RRO Housing Assistance policy) to provide swift adaptations to enable safe and timely discharge.
- Prioritisation of hospital discharge referrals
- Attendance of housing teams at hospital multi-disciplinary meetings where the discharge is complex and potential housing issues are identified to improve outcomes and system flow.

Our progress in implementing the High Impact Change Model for managing transfers of care.

East Sussex system partners recognise and agree the impact and importance of system flow on patient experience, quality and safeguarding, costs and efficiencies and elective care recovery. The Sussex ICS approach is aligned to our strategic system wide work that incorporates a whole system approach across improved efficiency, admission avoidance, hospital discharges, developing enhanced community responses and growing our virtual wards.

This has patient experience and outcomes at the heart of our work and has been informed by quality and equality impact assessments, the high impact change actions along with hospital flow and discharge pathways as part of the Discharge Front Runner programme.

East Sussex Healthcare NHS Trust, supported by the Emergency Care Intensive Support Unit have reviewed patient flow and identified actions aligned to the High Impact Change Model along with other plans outlined in the East Sussex BCF Plans.

Impact Change	**East Sussex Actions**
Early Discharge Planning	Review Ward and Board round processes, moving from sequential of patient actions, to actions in parallel.
Monitoring and responding to system demand and capacity	Ongoing review of bottlenecks.
Multi-Disciplinary Working	Build on “Frailty Ward” to develop short stay frailty unit with enhanced therapy input.

	Review use of Therapy resources with a more proactive approach
Home First /Discharge to Assess	Work with discharge hub to ensure better feedback and further optimising all pathways.
Flexible Working Patterns	Improve Weekend and Monday discharges, Improved use of discharge lounge
Trusted Assessment	Identifying and implementing Trusted Assessor opportunities
Engagement and Choice	Continued implementation of the new system Choice Policy based upon best practice
Improved Discharge to Care Homes	Increased capacity within Discharge to Assess pathways for bed-based capacity.
Housing and Related Services	Understand and act on current delays for equipment and adaptations

BCF schemes supporting improvements in hospital discharge pathways.

Housing adaptations have been utilised to enable residents to be discharged to usual place of residence via the use of discretionary policies to support with fast tracking works, developing pathways with hospital discharge teams to enable hospital discharge referrals to be prioritised and, where the existing place of residence is not suitable for adaptations, support with options for identifying and relocating to alternative accommodation.

Assisted Discharge Service provided by British Red Cross with additional capacity through the Discharge funding.

Introduction of Personal Health Grant to provide low level support which facilitates hospital discharge.

Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.

Increased capacity within Discharge to Assess for both Domiciliary Care and bed-based capacity.

How East Sussex HWB have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered

Through services funded via the BCF, 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.

These BCF funded services in East Sussex include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.
In East Sussex, much of the BCF funding is used to provide services which support the delivery of duties under the Care Act:

Health and Social Care Connect (HSCC) is the East Sussex Single Point of Access to community services and also provides a single point for internal staff and external partners to raise safeguarding concerns.

Support for unpaid carers including young carers, carers who are working and older age carers - further details can be found in the next section.

7. Supporting unpaid carers:

Through the BCF, a wide range of services are jointly funded and commissioned to support unpaid carers including:

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 and for young adult carers
- Working with Primary Care practices in the most deprived areas of Hastings and the Havens to reach carers with the most complex needs/caring roles.
- Undertaking carers' reviews on behalf of ASC
- New NHS funded services for 23/24 – the Havens (above) plus carer identification, awareness, and direct support in the acute trust to assist with hospital discharge.

Outcomes for unpaid carers:

- 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.
- Improved outcomes for carers in primary care
- Evening support group and targets mental health support group reach working age carers.

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
- Young Carers – a separately commissioned service to provide young carers assessments, individual and family support, workshops and in-school support groups which seek to reduce levels of inappropriate caring and their social, emotional, health and educational needs.

Small Grants (funding now held and allocated by Care for the Carers)

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)

8. Disabled Facilities Grant (DFG) and wider services:

The 2019/20 Annual Report of the Director of Public Health focuses on Health and Housing in East Sussex. Annual Public Health Report 2019/20 - Health and Housing | East Sussex: Joint Strategic Needs Assessment (eastsussexjsna.org.uk) This included the following statements of intent considering opportunities to improve housing in East Sussex.

- **TO MAKE ALL HOUSING AND NEIGHBOURHOODS HEALTHY**: East Sussex County Council and the District and Borough Councils will work more collaboratively on each of the Local Plans through the existing groups - Local Plan Managers and the East Sussex Housing Partnerships Board , sharing data and intelligence to fully understand housing needs and population distribution and hardwiring the principles of "Putting health into place" to ensure health is central to place making, and the design and delivery of homes and neighbourhoods.
- **TO MAKE ALL HOMES HEALTHY**: East Sussex County Council, the District and Borough Councils and the NHS will support and promote initiatives that improve the health and safety of homes, including adaptations that improve environmental sustainability, and promote independent living.
- **TO MAKE PEOPLE HEALTHIER IN THEIR HOMES**: East Sussex County Council, the District and Borough Councils, the NHS and the voluntary and community sector in East Sussex will collaborate to integrate the planning and delivery of care and support in housing, ensuring that specific homelessness and rough sleeping support is continued.

Healthy lives, healthy people: East Sussex Health and Wellbeing Board Strategy | East Sussex County Council sets out the overarching vision supporting the residents of East Sussex and highlights the importance of high-quality safe housing and its impact on health and wellbeing

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 Partnerships Board 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.

The East Sussex Housing Partnerships Board provides a countywide strategic approach to housing and support issues and oversees effective use of the funding available, including use of adaptations to support independent living and any cross-county projects.

Secondment of specialist Adult Social Care Occupational therapy housing teams into District and Borough Councils in 2019 has allowed for provision of integrated, co-located housing related services including housing adaptations and a move away from the more traditional non-integrated two-tier approach that was previously employed in East Sussex.

This joining up at an operational level as recommended in the DFG review 2018 has enabled a single point of referral, simplification and speeding up of the client journey and an increase in the number of major and minor adaptations, where adaptations are not possible the Occupational Therapist can assist with exploring options available to them and advise about the most appropriate housing solution to meet their needs.

The team use prevention and personalisation to reduce health inequalities, supporting people to live as independently as possible through a greater focus on outcomes and the wider determinants of health in our community, and enabling more people to access more adaptations at the right time for them.

Five unqualified OT staff have received training to enable them to carry out a Trusted Assessor role allowing the assessment and recommendation from simple DFG adaptations such as stairlifts and level access showers, enabling qualified OT staff to focus on the more complex assessments.

Referral routes have been streamlined and are accepted from a wide variety of sources, preventing delays in accessing services, consistency of approaches across areas provides greater equality. Closer working between organisations has meant more timely access to the service and an ability to resolve problems as they occur and with minimal impact on the tenants.

Referrals are screened and triaged based upon a priority and those where risks are highest or requiring support to be discharged are prioritised.

The team can access the full suite of Adult Social Care support by completing Care Act Assessments and are trained in assessing equipment, adaptations, telecare, carers assessments, mental capacity, and safeguarding, they can provide daily living equipment and minor adaptations via the local Integrated Community Equipment service.

They work collaboratively with colleagues from Social Care, Wheelchair services, Health, Voluntary and Housing sectors to consider options to meet individuals' needs.

An innovative example is accessing funds for a 'third party top-up' towards a wheelchair provided by the wheelchair services to enable an additional rise and fall element to be fitted to the seat of the chair, allowing the individual to access higher shelves within their kitchen but also assisting them to access shelves within their local supermarket and have conversations at eye level.

Support is provided with rehousing; either via accessing discretionary assistance to finance moving costs, part-buy schemes to purchase an adaptable property (recently cited as an example of Best Practice by Foundations) or local housing registers. Options are fully explained and referrals to organisations such as Brighton Housing trust or internal Housing Solutions workers made. Assessments of temporary accommodation and adaptations and equipment in alternative housing are also carried out. Interim risk management measures are also provided.

Assessments are undertaken for individuals regardless of whether they live in public or private sector housing. For individuals who are identified as self-funding adaptations are offered information and advice to ensure their needs are appropriately met.

This service has successfully won the DFG team of the year award by Foundations in 2022.

The following services have been or are in the process of being developed to use housing support, including DFG funding, to support independence at home:

- Integration and co-location of Housing OT Service into DFG teams
- Review and updating of discretionary DFG policies, using the joint strategic needs assessments to identify gaps in service provision and focus on place-based provision of

services tailored to the needs of the specific communities within district or borough areas aiming to address health inequalities.
- Development and adaptation of temporary accommodation that supports independence for users who are disabled.
- Working with housing development teams to ensure requirements for accessible and adaptable new build housing is tailored to the needs of the local population and addresses current shortfalls.

In addition to BCF funded Housing support there are a range of other Housing Support services across East Sussex including:

- Extra-care facilities
- Shared lives/ Supported accommodation: a number of planned developments for supported living and potential shared lives placements over the next 3 years.
- Floating support services
- Homelessness and Rough Sleeper initiatives
- Telecare and Telecheck services
- Warm homes teams
- Mental health services links with housing
- ESCC pilot of assistive technology (Alexa)
- Linked smoke alarms, jointly funded with East Sussex Fire and Rescue services

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? **Yes**

The amount allocated for these discretionary uses is £4,061,806 per annum. Further information can be found at:

Disabled Facilities Grants in Hastings

Eastbourne Housing Strategy 2020-2024 - Lewes and Eastbourne Councils (lewes-eastbourne.gov.uk)

Housing Financial Assistance Policy 2021-2025 – Rother District Council

Discretionary Assistance for Disabled Occupants - Wealden District Council - Wealden District Council

9. Equality and health inequalities

The East Sussex partners 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.

We'll 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 described in the wider determinants of health section. We believe that collectively our organisations can make a real difference to our population's economic and social wellbeing.

East Sussex is a county with a growing and ageing population. By 2026, almost one in four people here (24%) will be aged 65 to 84. For England as a whole, that figure is nearer one in six (17%). More than 4% of our population will be over 85. This compares to less than 3% for England as a whole.

With more older people, which includes those who are frail and have multiple conditions, East Sussex is likely to have higher health and care needs than other areas of our size. This rise in demand is just one part of our health and care for the whole population.

By 2028, around 20,000 more people in East Sussex will be living with two or more long-term health conditions than was the case a decade earlier.

The number of children in need of help and protection is rising locally and nationally, linked to the increase in families with financial difficulties. There is also a rise in the number of children with statements of special educational needs and disability (SEND), some of whom will have complex medical and care needs.

East Sussex is both rural and urban, which brings challenges in ensuring the right access to services and at the right quality. Our coastal communities reflect the patterns of inequality and poverty highlighted nationally in the Chief Medical Officer's report from 2021 and there is also hidden poverty in our rural areas.

On average, our population's health is similar to England's but there are wide variations within East Sussex. People in deprived areas tend to be affected by poorer health. The gap in life expectancy between our most and least-deprived areas is more than 11 years for men and almost 10 years for women.

A person's chance of enjoying good health and a longer life is influenced by the social and economic conditions in which they are born, grow, work, live and age. These affect the way people look after their own health and use services throughout their life. The poorer your circumstances, the more likely you are to have poor health and wellbeing, spend more of your days with life-limiting illness and die prematurely. This requires joining up NHS and social care with other services provided by the County Council, district, and borough councils, the voluntary, community and social enterprise sector and other services and businesses that affect people's lives, health, and social or economic wellbeing.

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.

We want to reduce health inequalities for our population. This will be measured by inequality in healthy life expectancy at birth. It will require us to work differently on 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 each individual's strengths and potential vulnerabilities. Every opportunity will be explored to make sure we improve our ability to do this.

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 causes of ill health to prevent premature death and the overall prevalence of disease. 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:

- early cancer diagnosis
- chronic respiratory disease
- hypertension case finding to minimise risks of heart attacks and strokes.
- continuity of maternity care
- annual health checks for people living with serious mental illness and learning disabilities.

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

- Carers.

- LGBTQ+ groups

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.

We will prioritise the improvement of healthy life expectancy tackling the key health inequality related conditions and ill health through:

- Supporting individuals and populations to adopt healthy behaviours, including promoting and supporting healthy weight, and action to reduce harm from alcohol and tobacco.
- Addressing the social and emotional factors that influence health in our communities, including the 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 and insight, to help frontline teams understand current health and care needs and what factors are driving poor outcomes in different population groups. This will result in more proactive models of care which will improve health and wellbeing today and in future years.

The BCF in East Sussex funds a wide range of services provided by the VCSE sector. These services include community hubs, community connectors, benefits advice, and access to community-based support for people with sensory and mental health needs.

The East Sussex BCF schemes are subject to the requirements of the commissioning partner organisations in respect of Equality Impact Assessments. Consideration is given to the level of the schemes' impacts on the wider determinants of health and Core20+5 priorities to reduce health inequalities.

The East Sussex BCF is embedded in the local health and social care economy and broader plans and as with wider health and care, services funded via the BCF need to ensure they are accessible for people with protected characteristics and / or experience health inequalities.

To support shared accountability for delivering the vision and the outcomes, our Health and Wellbeing Board has brought together a small number of strategic outcomes that we all share and have agreed we will work together to measure and improve. We are continuing to make sure that these align with our developing ICS strategy and framework.

The outcomes are based on what local people have told us is important about their health and care services and other areas. These have been used to inform this strategy as well as our East Sussex Health and Care Plan and programme and the other strategies and plans that will support delivery of this strategy.

Outcomes are set out under four headings:

- Population health and wellbeing
- The experience of care
- The quality of care
- Transforming services for sustainability

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.