EAST SUSSEX HWB

BETTER CARE FUND 2025-26 SUBMISSION

	HWB Area 1
HWB	East Sussex
ICB	Sussex

Section 1: Overview of East Sussex BCF Plan

Priorities for 2025/26

The East Sussex Health and Wellbeing Board Better Care Fund priorities for 2025/26 align to local needs through the East Sussex Health and Wellbeing Strategy and the Sussex-wide joint Improving Lives Together strategy which outline our ambitions to implement integrated care at scale, and to shift the model of care from Treatment to Prevention, Hospital to Community and Analogue to Digital.

Our Integrated Community Teams model for health, care and wellbeing, as set out in our Sussex Integrated Community Teams Neighbourhood Health Plan, will take a level of needs pyramid approach, providing Neighbourhood services to those with the highest care needs, ongoing care needs, urgent care needs, and services tailored for the whole population. These will be enabled by an Improving Lives Together (ILT) programme, provider collaboratives, VCSE/hospice alliances with SMART outcomes defined for each level.

The Neighbourhood approach will ensure that commissioning and services recognise the shift to a community-first approach that has a preventive, proactive and community empowerment embedded within services. By delivering Integrated Community Teams (ICTs) within the supported communities, they will be configured to meet their local context and needs:

- Local authorities, the NHS, and the VCSE sector will work together to prevent people spending unnecessary time in hospital or care homes
- Strengthened primary and community-based care will enable more people to be supported closer to home or work.
- Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

Integrated Community Teams will enable a “no wrong front door” approach, with services and support networks working across organisational boundaries and communities to deliver joined up care, creating a focus on doing the best for people, and developing new approaches to contracting to support a partnership approach to integrated care, reallocation of resources putting more resources into the community and proactive preventative care. ICTs will deliver the aims of avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life.

Our priorities for discharge during 20256/26 are to enhance and improve patient flow through a focussed improvement of the number of people who are discharged from hospital on their discharge ready date, reducing the average delay in discharge days, and driving collaboration and integrated working. We will continue to embed Discharge to Assess (D2A) principles system wide. This will involve assessing short-term care needs at home post-discharge and undertaking long-term care assessments after an appropriate recovery period.

Local partners are working with the Provider Collaborative, primary care, community care providers, hospice and VCSE Alliance to agree a service specification to provide holistic integrated care that meets the health needs of patients with highest, ongoing, urgent and complex care needs to support the strategic direction of travel and deliver the Integrated Community Teams at scale and on a sustainable footing. The aim is to align commissioned services appropriately, guided by shared objectives, outputs and outcomes.

Key Changes Since Previous Plan

The majority of BCF schemes within the previous BCF plan for 2024/25 both council and ICB commissioned remain closely aligned to core BCF funding requirements, the updated BCF objectives, our joint strategy for Sussex, and our delivery ambitions for 2025/26 and beyond via Integrated Community Teams. There is close alignment between BCF plans, our planned delivery of Integrated Community Teams, and the joint working approach that will sustain this delivery, supporting reform to support the shift from sickness to prevention.

Our planned schemes support people living independently and the shift from hospital to home include community equipment services, urgent community response, and the ongoing development of the neighbourhood-based ICTs. Schemes also support the continuing requirements to fund reablement services, carers breaks and Care Act duties.

For hospital discharge, we have followed a collaborative process of co-design with key stakeholders, including East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, the Integrated Care Board, Social Care, and acute partners. This has been supported through our Place based Discharge Transformation Group that is chaired by the Director of Adult Social care and Health. The primary focus has been on stabilising and sustaining existing schemes that are delivering the most significant impact, while also reviewing underperforming initiatives to understand barriers to mobilisation and effectiveness. This approach ensures that funding is directed towards new interventions that will enhance patient flow, reduce delays, and improve outcomes.

Our ambition is to increase the proportion of patients discharged on their Discharge Ready Date (DRD) and reduce the average delay from DRD to actual discharge. Specific targets include reducing Non-Criteria to Reside (NcTR) occupancy of all acute and community beds. Site-specific discharge plans are being developed, supported by Better Care Fund resources to maximise Pathway 0 and 1 discharges. A comprehensive review and reset of Pathway 2 will ensure full alignment with the Intermediate Care Framework and integrated care team plans, with full implementation expected by January 2027.

Discharge schemes have been developed and agreed based on the established priorities of the BCF, key recommendations from the Sussex Bolton report and the outcomes of recent discussions with the Discharge Support and Oversight Group.

These include supporting more people to return home safely, enabling recovery through therapy and reablement to maximise independence, developing specialist pathways for those with complex needs, and enhancing acute sector capacity by reducing unnecessary delays.

In developing the overall BCF plans for 25/26, reflections and key learning from 24/25 have been taken in account. To support transformational change and shifts in system working across health and social care, our plans reflect a level of continuity with sustained commitments that enables our system partners to direct capacity and capability towards further integrated ways of working. A change in impact to be had from the plans will come from the synergy of integrated working at neighbourhood health and ICT level to deliver early interventions in proactive care and system flow to reduce avoidable admissions to hospitals and residential care, and to facilitate discharge to reablement and assessment. The planning approach building on the learning from recent years has identified schemes that support the BCF objectives and delivery against national metrics and which align with local strategies. The schemes support the development of strategic system partnerships across NHS community-based care, social care and VCSE partners as part of wider health and social care commissioning to work differently to maximise the potential from integrated neighbourhood ways of working.

Work is also underway on developing our approach to understanding measurable impacts through the HWB's Shared Outcomes Framework. The East Sussex Population Health and Care Intelligence Group has supported the development of a proposal for review by the East Sussex Health and Care Partnership to pilot use the HWB Shared Outcomes Framework, to help us understand how we might collectively measure the impact of our whole system working, for adoption in 25/26.

Approach to Joint Planning & Governance

The East Sussex Better Care Fund Plan is co-produced by the partner organisations, drawing upon commissioners, finance leads, and performance and intelligence teams.

The East Sussex Health and Wellbeing Board which, in addition to the Council and Integrated Care Board, includes representation from NHS Providers (acute, community, and mental health), VCSE organisations and wider community organisations.

The East Sussex Health and Wellbeing Board retain statutory responsibility for governance and oversight of the Better Care Fund and receive quarterly monitoring reports. We expect any engagement with the BCF oversight and support process to be primarily at this level.

The East Sussex Health and Care Partnership brings together key local health and care partner organisations to work collaboratively to deliver the objectives of the Joint East Sussex Health and Wellbeing Strategy and the Sussex-wide Improving Lives Together strategy through a place-based focus.

We have an effective governance structure in place which operates at both place and Sussex-wide level to oversee BCF planning submissions and quarterly reporting prior to sign-off by the Health and Wellbeing Boards which is supported by our finance and

performance teams. This will further evolve to support reporting and engagement for 2025/26.

Partners and stakeholders are engaged through the East Sussex Leadership Groups that are delivering the Sussex-wide Integrated Community Teams plan which is supported by the East Sussex BCF plans.

There is work in place with Local Authority teams (Public Health, Social care and Housing), with NHS and VCSE Providers to implement ICTs supported by the Sussex Provider Collaboratives and the Sussex Voluntary Sector and Hospice Alliances. East Sussex Adult Social Care also works closely with East Sussex Partners in Care (ESPIC) which represents care providers and managers of adult social care services across East Sussex. These relationships will form the delivery vehicle for integrated health and care services, working in partnership with other key stakeholders such as schools, employment support, leisure services, and the Department for Work and Pensions

We have maintained a winter provision in the plan with expenditure profiled to ensure we respond to additional pressures in our hospital discharge system during the winter. This provision also allows us to run on some services that were stood up this winter past March 2025 to support current pressures in our hospital discharge system.

Alignment with Improvement of UEC Flow

Our ambition is to ensure that every patient in Sussex experiences a safe, timely, and seamless discharge from hospital, with the right support to promote independence and long-term recovery. By focusing on patient well-being and working collaboratively across health and social care, we aim to create a more responsive and effective discharge system. Building on the learning from 24/25, our programme for the coming year is guided by a specialist health and social care team and informed by an in-depth audit led by Professor John Bolton, who has helped shape the national model of excellence for discharge pathways.

Delays in discharge remain a significant challenge across the system, with key factors varying by location. Some of the most pressing issues include capacity constraints in NHS community services, including both beds and HomeFirst pathways, as well as delays in social care assessments and care package allocation. The availability of residential care within a constrained market continues to impact discharge flow, and non-clinical processes can also create delays in ensuring patients have everything they need to return home safely.

To address these challenges, we are investing in expanding our HomeFirst model, enabling more patients to return home sooner with the right support. We are strengthening therapeutic interventions from hospital admission through to discharge and community-based reablement, ensuring that care is designed around recovery and independence. Additionally, specialist bedded pathways in the community, including those focused on delirium care, will receive targeted investment to improve patient outcomes. Reflecting the significant progress made in mental health discharge during

24/25, we are balancing our place-based discharge investments with new and existing mental health schemes, ensuring better support for those with dual physical and mental health needs.

Beyond direct patient care, our strategy includes enhancing system-wide coordination and flow management. The continued development of the Transfer of Care Hubs (TOCH) dashboard, alongside improved data tools and enhanced decision-making processes, will enable us to optimise discharge planning across all care settings. We are also introducing dedicated projects to benchmark acute hospital performance and share best practices across the system, ensuring that local improvement plans are tailored to the specific needs of each population.

Through these investments, we expect to see faster and safer discharges, improved patient recovery, and a more resilient system that adapts to demand. By reducing delays and increasing efficiency, we can enhance patient experience, prevent unnecessary hospital stays, and improve overall capacity across health and social care. The strengthened coordination between NHS services, local authorities, and community partners will ensure that patients receive the right care in the right place at the right time, making discharge a seamless and positive transition

The community services in our BCF plan support the ambition for standardised and scaled up urgent care services for people in the community such as urgent community response. These urgent neighbourhood services will align with local demand, and services at the front door of the hospital such as urgent treatment centres and same day emergency care, and within the hospital enabling some patients to bypass Emergency Departments.

Access is through our single point of access, Health and Social Care Connect (HSCC) delivering a co-ordinated service, hospital front door services also increasingly accessed through HSCC.

Integrated intermediate care services such as our Joint Community Rehabilitation Service will ensure step-up pathways to prevent avoidable admissions and step-down pathways to support timely and effective discharge from hospital.

Priorities for Intermediate Care

Our priorities for intermediate care are aligned with the national framework via initiatives including our reablement plans, prioritisation of Home First discharge, and provision of proactive care.

Neighbourhood health services will include Home First and person-centred approaches so that appropriate risk-based decisions are made, and hospital care only used when clinically necessary, supporting continuity of care in the community for people under the care of a specialist hospital team such as respiratory, diabetes, stroke or cardiology.

Through our clinically led commissioning approach, we have translated and interpreted national plans contextually for Sussex, to develop our Rehabilitation and Reablement vision. This is a product of the collaboration and learning across our multiple partners,

offering us a shared view of how we progress the future design and delivery of services for our population.

This needs-led, personalised, and proportionate approach provides the opportunity to skill mix and match our workforce to provide the appropriate intervention. This offers us a framework to look at our current provision, particularly given the rehab inequality that exists for people with similar needs but differing diagnoses. It also ensures that we are productive and fiscally responsible with existing resources, and that we have a responsive infrastructure and workforce.

Our Sussex Transfer of Care Hub (TOCH) model, supported by system-wide demand and capacity planning for Intermediate Care, will deliver best practice via recruitment and retention, culture change, the development of TOCH leadership structure, and a Rehabilitation and Reablement Community of Practice.

Section 2: National Condition 2 – Implementing BCF Objectives

Sickness to Prevention:

The Sussex-wide Improving Lives Together strategy aims is to shift the model of care to prevention and East Sussex Better Care Fund plan includes significant investment in community services that support this approach.

We will strengthen this focus by strategically aligning partnerships and working to support our shared priorities for delivering a joined-up offer for health, care and wellbeing, including prevention, across NHS, local government and VCSE sector services for our population.

The East Sussex HWB are running a programme of deep dive sessions at quarterly intervals prior to the formal HWB meetings up until February 2026, structured around the priority themes in our East Sussex Joint Strategic Needs Assessment (JSNA), aimed at deepening the shared understanding of our population's health and care needs and priorities.

The sessions are helping to strengthen the relationships and mutual accountability needed for whole system collaboration in the challenging financial context being experienced by all our organisations.

Work is also underway on developing our approach to understanding measurable impacts through the HWB's Shared Outcomes Framework. The East Sussex Population Health and Care Intelligence Group has supported the development of a proposal for review by the East Sussex Health and Care Partnership to pilot use the HWB Shared Outcomes Framework, to help us understand how we might collectively measure the impact of our whole system working, for adoption in 25/26.

Hospital to Home:

The Implementation of the ICTs will take an asset-based approach seeking to build on existing human, social, cultural, physical (estate) and environmental resources when addressing the challenges and realising the aspirations of a community that is moving away from traditional models of care and support which focus primarily on the deficits.

Learning from the 24/25 Winter response in primary and community care and the ICTs tests of change will all be taken forward at scale with the aims of avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life. The key success measures will be:

- avoiding admissions to hospital / referrals to secondary care,
- reducing referrals from care homes or escalated levels of social care support

- Keeping people at home
- Reducing length of stay in hospitals get them back home

Engagement has taken place with over 600 people to support the development of Integrated Community Teams in five East Sussex footprints aligned with our borough and district boundaries. This builds on the success of our Hastings community frontrunner and the Universal Healthcare programme which brought people together to understand how the NHS could design services so that everyone has a fair chance of access and care.

In 25/26, working within the Sussex-wide framework we will build on these strong foundations in the following ways:

- Putting in place the formal local leadership arrangements for management and planning in each East Sussex ICT footprint across the resources in scope
- Develop, agree and start to deliver a joint action plan in each ICT footprint building on the tests of change and supporting strategic and local priorities aligned to the population health challenges and local opportunities in each footprint
- Continue to build strong relationships across the wider networks of support available in each footprint through working with VCSE partners
- Co-designing a consistent approach to MDT-working for people with complex needs across East Sussex, based on good practice and the recommendations from the MDT survey, including agreement of standards, coordination of meetings and working culture
- Work with NHS Sussex on a draft specification for core ICT related services and how we can jointly enable system partners to respond to this.

Based on the in-depth audit led by Professor John Bolton our plan has increased our investment in our reablement services to avoid or reduce health deterioration, the risk of hospital readmission and to promote independence in the community

Joint Approach to Best Value:

Our priorities support the shift from sickness to prevention and from hospital to home and a home first approach. We will deliver proactive, planned and responsive care, and prioritise that care based on individual people's needs, with health and care partners working together for greatest impact. We will make best use of all funding arrangements, including those that are formally pooled, to facilitate partnership working with the objectives of improving outcomes, access and experience for the local population and ensuring value for money.

All Integrated Community Team partners will work collectively to deliver the following outcomes which support our prevention-based model of care:

- Reduction in emergency admissions to hospital for people aged 65 and over
- Reduction in unplanned hospital admissions for chronic ambulatory care sensitive conditions

- Reduction in emergency hospital admissions due to falls in people aged 65 and over
- Reductions in avoidable admissions, particularly of more frail patients where this can lead to adverse patient outcomes
- Increased use of Virtual ward with expanded focus on admission avoidance and the number of discharges from the acute on HomeFirst pathways
- Percentage of discharges to a person's usual place of residence
- Improved Medicines use and reduce harm from inappropriate polypharmacy
- Increase the incidences of people dying in their preferred place of death
- Increased implementation of digital integrated care plan

Our plan supports the necessary joint programme leadership, and local learning through tests of change, to enable the work and development of our new Integrated Community Teams in delivering the outcomes detailed above.

Metrics Ambitions Support Alignment to System Partner Plans/Capacity & Demand:

For the Health based measures, the figures in the BCF plan reflect the provider submissions to the Operating plan at point of signoff at the boards. These plans will be further developed in year to reflect all ambitions for improvement in the system and identifying areas for improvement, refining flow and driving change comes through a process of continuous improvement.

Home First Approach:

Our aim is to ensure that the principles of Neighbourhood first, person-centred, preventive and proactive approach is adopted working through Integrated Community Teams. System-wide and collaborative 'Home First' prioritisation will deliver short-term rehabilitation, reablement and recovery services (integrated intermediate care), a therapy-led approach working across health and social care and other sectors. Referrals will be made directly from the community (step-up) or as part of hospital discharge planning (step-down), with assessments and interventions delivered at home wherever possible and working closely with urgent and community neighbourhood services.

Through this needs-led, personalised, and proportionate approach, we can skill mix and match our workforce to provide the appropriate intervention. This offers us a framework to look at our current provision, particularly given the rehab inequality that exists for people with similar needs but differing diagnoses. It also ensures that we are productive and fiscally responsible with existing resources, and that we have a responsive infrastructure and workforce.

Under our person-centred approach:

- People will be involved in planning for their discharge early in their inpatient stay and will be discharged to their normal place of residence with the required level of care and support or to an appropriate community or care facility without significant delay as soon as they are declared medically fit to do so.

- People will experience a seamless transition between our services as part of their discharge pathway.
- People will be discharged earlier but receive ongoing clinical oversight where required through the use of digital innovations such as remote monitoring.

Consolidated Discharge Funding:

Our investment in discharge improvement for 2025/26 builds on the lessons learned from the past year and reflects the progress we have made. The outcomes from our 2024/25 initiatives have reinforced the importance of targeted interventions that improve patient flow, reduce delays, and enhance recovery in the community. While there is still significant work to do, this funding forms part of a wider commitment to transforming discharge pathways and supporting more people outside of hospital. We have taken a best-practice approach, aligning our strategy with the John Bolton report for Sussex, which emphasises faster flow, greater therapeutic input, and reablement-focused care. This has shaped our investment in the Home First pathway, ensuring it delivers real transformational change, alongside targeted investment in specialist reablement pathways.

Our Transfer of Care Hubs (TOCHs) will continue to strengthen, providing a more coordinated and efficient discharge process. Using detailed data and analysis, we have carefully matched funding to population needs, taking a site-level approach with tailored performance targets and action plans for each acute and community provider.

This collective effort will ensure a more sustainable, patient-centred system, enabling a strategic shift towards delivering more care in the community and reducing reliance on hospital beds within the acute and community settings.

Intermediate Care Capacity & Demand:

Services providing health and social care in the community provide a broad level of care provided by a range of skilled professionals, they provide supported discharge, admission avoidance, ongoing patient care, crisis management which would not result in an admission etc. Patients requiring supported discharge and admission avoidance have a wide variety of needs which can require multiple services for a range of reasons. Data tends to exist for contractual and quality purposes, additional data requirements require incentives which need to be balanced against the patient centred role of the staff. These contractual purposes do not typically prioritise the source of patients but we are looking to develop this in the system.

Services for inclusion were included as a whole and proportion related to the relative splits in the file were applied following conversations with the local system. The nature of data provision in contracts varies between health and social care and tends to be more explicit in health contracts.

The demand and capacity model for 25/26 is a further development of the 24/25 demand and capacity methods.

Discharge demand is primarily based upon the main East Sussex providers of ESHT, UHSx and MTW with local data identifying which ones are East Sussex patients.

Admission avoidance demand is based upon the flow into the identified services which provide the support. This will miss any demand in excess of supply, which would overflow into emergency admissions but the recording of emergency admissions would not identify if patients attempted to access avoidable admissions.

Section 3: Local Priorities and Duties

Promoting Equality & Reducing Inequalities:

Addressing health inequalities is a core aim of Improving Lives Together and is the driving purpose of developing Integrated Community Teams that better meet the needs of our diverse local communities. Health inequalities is a key priority of all our Health and Wellbeing Strategies and is a key element of all the workstreams of our Shared Delivery Plan and will be embedded within many of the actions outlined. This will be done with the following commitments

- Co-production – working with those with lived experience to design and delivering change.
- Interventions – investing in prevention, personalised care, and other activities to drive reductions in heath inequalities.
- Funding – focusing a greater amount of funding based on need.
- Design of services – undertaking Equality and Health Inequalities Impact Assessments for all service changes.
- Visibility – ensuring every decision we make considers the impact of proposals or decisions.
- Outcomes and performance – considering the differences across geographical areas, population groups and other factors in how we set and monitor outcomes and performance.
- Workforce – actively recruiting, develop, and support people from our diverse communities.
- Net Zero and social value – using our resources and assets to help address wider social, economic, or environmental factors.
- Data quality and reporting – driving work to both improve and increase the recording and reporting of data by key characteristics.

Engaging or Consulting:

In addition to discharging the statutory duties of the partners to engage or consult with people affected by proposals, and engage with communities, we have brought people together to introduce the concept of our Integrated Community Teams delivery plan which is strongly aligned with BCF objectives and schemes to discuss how this might develop locally. Within East Sussex 17 engagement activities were held involving over 600 people across the 5 ICT footprints with the aims of building relationships, developing new ways of working, gaining an understanding of the health inequalities experienced by communities, and improving access to health services. This builds on the success of the Hastings community frontrunner, Universal Healthcare, which brought together over 317 people in Hastings from the NHS, Local Government, Third Sector, business and education.

The NHS Sussex Strategic Commissioning Policy takes an outcomes-based approach which, in addition to being data driven and involving all local stakeholders, involves service users in co-designing care pathways to ensure relevance and usability. ESCC Adult Social Care engage regularly with local CQC registered providers and local VCSE providers involved in the provision of care and support services which deliver against a number of BCF schemes.

Reducing Inequality in Access to NHS Services:

Across Sussex, system partners recognise and are actively addressing avoidable health inequalities in access to services, focusing on improving outcomes for disadvantaged groups through targeted interventions and co-production with communities.

Addressing health inequalities is a core aim of "Improving Lives Together" and is a key priority in all health and wellbeing strategies, as well as in the Shared Delivery Plan by way of:

- Population health management - to address and improve outcomes in six priority areas: cardiovascular disease, cancer, respiratory disease, early years, children and young people, mental health and learning disabilities, and inclusive NHS recovery.
- Working with people with lived experience to design and deliver changes, ensuring that services are tailored to the needs of the communities they serve.
- focusing funding based on need, ensuring that resources are directed towards those who need them most.
- Using Equality and Health Inequality Impact Assessments (EHIAs) to identify and address potential impacts of decisions on different groups, ensuring that services are accessible and equitable.
- Collecting and using data on health inequalities to understand the needs of the local population and to help take action to improve access, experience, and outcomes.

The Sussex Integrated Dataset (SID): plays a crucial role in improving health outcomes for the local population and reducing health inequalities by ensuring that the right services are available in the right areas.

Supporting and Involving Unpaid Carers:

We have produced a multi-agency partnership plan for carers of all ages. It is a public commitment setting out priorities to meet the needs of carers in East Sussex across our services. This will be for 5 years from January 2025. Care for the Carers, Amaze Imago (providers of adult and young carers support services) and NHS Sussex are our key partners who have signed up to the commitment to carers which can be found on our website along with the plan.

Throughout this plan we will consider the needs of all carers, including.

- parent carers
- young carers

- those from seldom heard communities.

The objectives of the partnership plan:

- Providing an overview of carers' needs in East Sussex.
- How we are currently meeting carers' needs.
- How we may need to use resources in the future.
- Addressing, where possible, identified gaps in carer support.
- Increasing identification of carers.
- Setting out how organisations will work together to continue to identify and support carers.
- Informing the commissioning of carers' services.
- Agreeing aims with key partners.

Carers partnership plan covers the following themes each of which have specific goals.

- Early identification, recognition, and intervention.
- Access to respite, breaks and carer support.
- Health and wellbeing.
- Financial support.
- Peer support.
- Employment, education and training.
- Technology and digital approaches.
- Partnership working.