East Sussex Better Care Fund Plan 2021/22

October 2021
Draft

Contents

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1. Executive Summary

The East Sussex health and social care system has a longstanding history and commitment to integrated working. Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of our collective resources in East Sussex. By developing a joint East Sussex health and care plan and having a clear place-based focus, we will ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of our local population.

The Better Care Fund is a critical element of delivering the East Sussex placed based plans as it provides the joint funding to support schemes which deliver on our local priorities.

1.1 Our priorities for 2021-22

Building on our journey to date and what has been delivered so far, our plans set out the work we need to do to further strengthen the way we work together at place level on our shared priorities, to deliver key outcomes for local people that continue to develop:

- Services that meet the needs of our East Sussex population
- Models of responsive, high quality, coordinated and personalised care, and supporting prevention, early intervention and wellbeing
- Improved population health and wellbeing, and reduced health inequalities across our diverse communities and groups in East Sussex
- Our shared priorities for transforming services through our integration programme.

1.2 Key changes since our previous BCF plan

Since our previous BCF plan our focus has increasingly been on the way we can further integrate our services to support people during the Covid-19 pandemic, including out of hospital support and discharge hubs to ensure timely discharge and appropriate care.

Our integrated senior management arrangements and the community health and social care services operating model established in 2019/20 have been critical enablers of the pandemic response across the whole of East Sussex.

In addition, we have also further developed our joint approach to improving population health and addressing health inequalities that have been highlighted by the pandemic. For example, the creation of five Community Hubs working with our District and Borough Councils as part of the pandemic emergency response to

support people who were self-isolating has brought new opportunities to further develop and align our partnership approaches to health and wellbeing, loneliness and social isolation, as well as wider work on social and economic wellbeing of our population. In addition our focus on neighbourhood and locality working will help to support prevention, population health management and early intervention as well as ensuring a coordinated offer of joined up care and support to people when they need it.

The Covid-19 pandemic accelerated new ways of working in more integrated and joined up ways to meet the significant challenges to restoring services, not only in hospitals, but also in social care, primary care, mental health and community-based services. This enabled new models of delivery that required a collaborative response and a flexible approach to deploying our resources including our workforce to meet system wide pressures, and this has provided significant learning to help reshape a stronger and sustainable future.

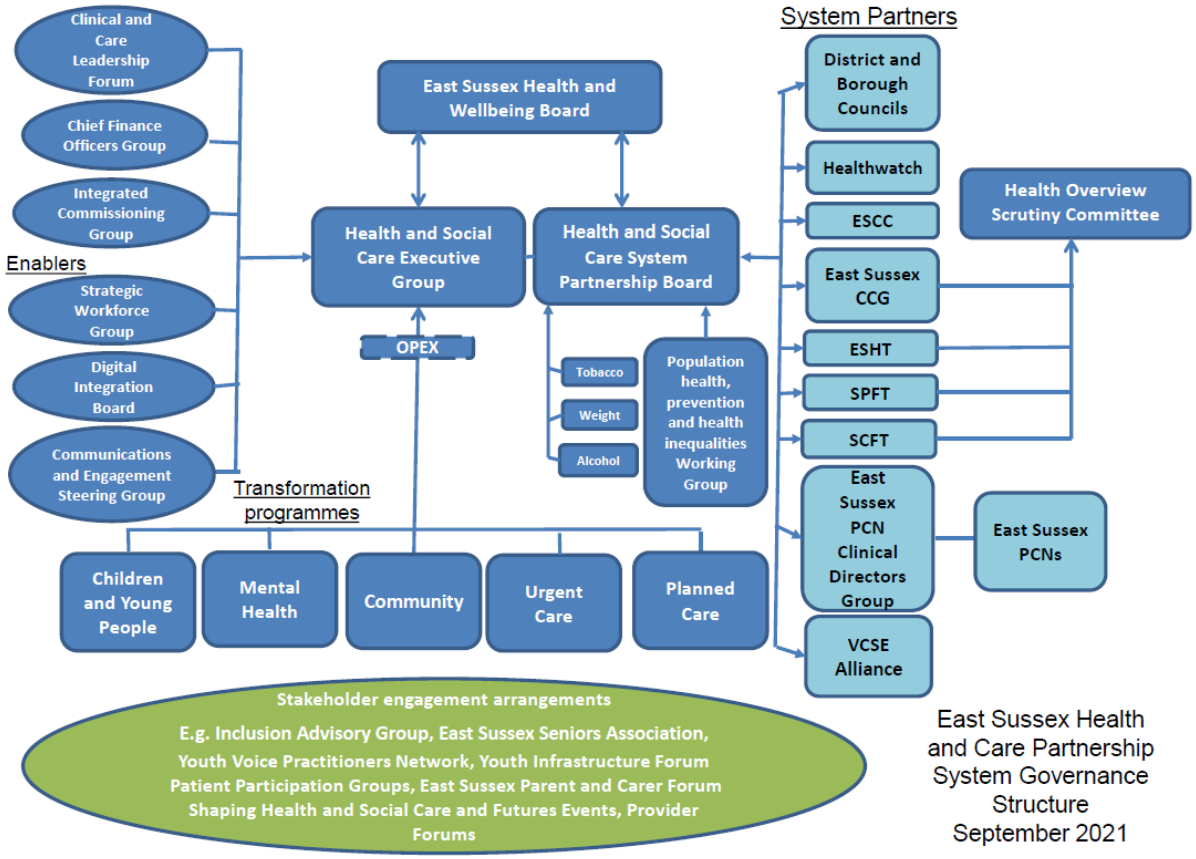
2. Governance

Our East Sussex Health and Care Partnership is our informal place-based partnership arrangement, bringing together East Sussex Clinical Commissioning Group, East Sussex County Council, East Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust.

Our system partnership governance includes the East Sussex Health and Social Care Executive Group and supporting Oversight Boards covering children and young people, mental health, community, urgent care and planned care, and we are working with our twelve Primary Care Networks to ensure they have a collective voice at all of these meetings. Our Health and Social Care System Partnership Board brings together our health and social care system with our District and Borough Council and Voluntary, Community and Social Enterprise (VCSE) partners to ensure alignment across all services that impact on the wider determinants of health. The partnership governance structure reports into the East Sussex Health and Wellbeing Board.

In addition to having a lead role in our East Sussex system, our organisations are also individually a part of the Sussex Health and Care Partnership (SHCP) alongside the upper tier and unitary Authorities, Clinical Commissioning Groups and NHS Provider Trusts in West Sussex and Brighton and Hove. The SHCP was formally awarded Integrated Care System (ICS) status in April 2020.

The BCF plans support delivery of the East Sussex transformation programmes, most specifically urgent care and community health and social care services. Schemes and services which fall within these areas are monitored via the relevant Oversight Boards. Collectively the BCF plans are overseen by the Integrated Commissioning Group alongside the Chief Finance Officers Group and report on a regular basis to the East Sussex Health and Social Care Executive Group. *See diagram below for further clarification:*



3. Overall approach to integration

The SHCP is on a journey of improvement and transformation. We have agreed a vision for 2025 that sets out where we want to be as a health and care system in the future. It is a vision where people live for longer in good health; where the gap in healthy life expectancy between people living in the most and least disadvantaged communities will be reduced; where people's experiences of using services will be better and where staff feel supported and work in a way that makes the most of their dedication, skills and professionalism. It is a vision where the cost of health and care will be affordable and sustainable in the long term.

This vision will enable every individual living in Sussex to have access to the best health and care from the moment they are born and throughout their lives. We want people to start their lives well, live their lives well and age well with a health and social care system that supports them in the very best way.

As a health and care partnership, we are committed to making our vision a reality. We recognise this will need continued cultural and behavioural shift across our system partners that remains focused on working together to find new and innovative ways of working and thinking and puts greater focus on outcomes and the wider determinants of health for our communities.

We have made significant progress in East Sussex and as part of the wider Sussex system, and it is encouraging that through the dedication and commitment of staff we

are delivering above average levels of activity and East Sussex is part of one of the top systems in the country in relation to recovery and restoration of services. Although we recognise there is more work to do to get to where we want to be, we are in a very strong position to take the next steps over the rest of 2021-22 in making our vision a reality.

3.1 Our joint priorities for 2021-22

Building on our initial shared response to the NHS Long Term Plan and our local priorities set out in our East Sussex Health and Social Care Plan (December 2019), our key priorities supported by the BCF are to:

- Build on our existing progress to enhance prevention, personalisation and reduce health inequalities and the gap in life expectancy and healthy life expectancy in the county. We will do this through coordinated action across all services that impact on the wider determinants of health such as housing, employment and leisure, as well as extending targeted approaches to empower people to make healthy choices across the whole life course to improve outcomes.
- Expand our support for people with mental health needs by ensuring access to a full range of services that support emotional wellbeing in primary care; enhanced support in the community to help avoid unnecessary admissions and support recovery; and working with housing teams and providers to support those people who also have housing and accommodation related support needs.
- Within our community services 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, including where people are at the end of their lives.
- Continue action to improve support for people with urgent care needs including targeted support for vulnerable people; improvements in urgent care processes and systems to deliver more streamlined urgent response; support people in care homes with urgent care needs;
- Further improve services that deliver planned care for local people for example continuing to support people with diabetes; and continue to support best practice with prescribing and medicines.

Our long-term East Sussex Health and Social Care Plan and priorities have been informed by what local people have told us is important to them about their health and care. Our plans are aligned across our organisations to support delivering these shared priorities and continue to test them with our stakeholders to guide how people want to be involved in shaping the way we deliver our ambitions.

3.2 Our approaches to joint/collaborative commissioning

Our local approach is supported by:

- Embedded integrated system leadership and planning arrangements to deliver against our population health priorities, NHS Long Term Plan requirements and ESCC priority objectives, and enable alignment of organisational plans across

our whole system to support health and wellbeing, with a strategic relationship to the East Sussex Health and Wellbeing Board for our system working and delivery of our agreed East Sussex Health and Social Care Plan and programme.
- An agreed shared outcomes framework for our system that covers population health and wellbeing, the quality and experience of care, and transformed services for sustainability (see the table above).
- A range of joint and integrated commissioning arrangements. This includes pooled and aligned budgets and a shared approach to system finances, shared arrangements for commissioning voluntary and community sector services, and significant joint work to understand additional care capacity requirements taking forward our agreed approach to bedded care both in and out of hospital through lead commissioner arrangements.
- Our shared integration delivery programme aimed at driving the changes needed to help manage growing demand on both NHS and social care services, by joining up care to support people to live as independently as possible and achieve the best possible health outcomes.

3.3 Our overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.

As set out in our long-term East Sussex Health and Social Care Plan, the key aim we share across all of our organisations is to improve the health and wellbeing of local people and reduce health inequalities in our population. This will be achieved through delivering more integrated and personalised care, and an enhanced focus on prevention, early intervention and reablement after episodes of ill health. In light of our population's health and care needs and our shared priorities and challenges we have committed to transforming to a new model of integrated care that will:

- Support people's independence through integrating care and offering a range of preventative services, early intervention and joined up care and treatment.
- Provide proactive support to people who are vulnerable or at risk as close as possible to where they live, and enable access to good quality local and specialist hospital-based services when they need it.
- Achieve this sustainably through greater levels of integration in our community health and social care services, working closely with Primary Care Networks, mental health services and local urgent and acute care services.
- Promote wider integrated working in our communities between the health and social care system and the full range of services that impact on the broader determinants of health and reduce health inequalities, including housing, employment, welfare, transport, environment and leisure and voluntary and community sector services and support.

In addition to our partnership delivery plans outlined above that are critical to improving health and wellbeing and reducing health inequalities in East Sussex, our strong priority to meet our population's health and care needs is more integrated care across all age groups.

In order to continue to progress our integrated community health and social care operating model and improve population health outcomes, after a year delivering the pandemic response, in 2021/22 we will:

- Build on our shared approach to the leadership and management of services across acute and community health and adult social care, to support the deployment of our resources and our teams to work together more effectively across services for the frail elderly and others with complex and long term care needs.

- Implement an integrated urgent response team approach aimed at enabling hospital admissions to be avoided where an alternative service can be provided, as well as supporting rapid discharge from hospital when people are medically ready to leave. This will take into account our learning from the pandemic, and also how it supports the overarching target operating model for community health and social care services (further detail is provided in section 9)

- Ensure a focus on the links and broader engagement with primary care and the VCSE as part of the community integration programme in 2021/22 to support the multi-disciplinary team (MDT) working and care coordination developments in primary care, and the implementation of anticipatory care (further detail is provided in sections 7 and 8)

- To support the above, agree and implement our approach and model for planning and delivering services in a geographically sensitive way within the county, to ensure strong links are made between core community health and social care services, primary care, mental health and other services that support people's needs holistically, for example the independent care sector, housing and voluntary and community sector services.

3.4 How BCF funded services support our approach to integration.

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 and the vision for integrating health and social care.
The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2021/22 seek to support the key priorities outlined above.

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

1. Enhance prevention, personalisation and reduce health inequalities
    a. Falls and Fracture Programme
    b. A range of services provided by the Voluntary and community sector including support for people with sensory impairment.
2. Support for people with mental health needs by ensuring access to a full range of services including
    a. Improved access to psychological therapies
    b. 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.
    a. Frailty services
    b. Carers Services
    c. Health and Social Care Connect (Single point of Access)
    d. Housing support and adaptations
    e. Maintaining social care services
    f. Community Equipment services
4. Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
    a. Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
    b. Crisis response
    c. Hospital Intervention team based in A&E
    d. Discharge to Assess - additional bed-based capacity
    e. Additional Domiciliary Care capacity
    f. Hospital discharge support
    g. 24/7 Health and Social Care Connect (Single point of Access)
5. Improve services that deliver planned care for local people
    a. Diabetes self-management and pharmacy support
    b. Medicines Optimisation in Care Homes
    c. Dietician support to medicines management

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

Many of the services funded partially or wholly through the BCF in 20/21 have been continued into this year. In addition to these, further investment has been made into domiciliary home care to support the system and in particular hospital discharge pathways.

4. Supporting Discharge (national condition four)

Health and care partners in East Sussex have worked together to develop detailed plans that cover the second half of 2021/22 and 2022/23 to support discharge and system flow. The aim is to provide a period of recovery and stability in hospital discharge and flow, to allow for the delivery of transformation and further development of a longer-term model.

Over this combined 18 month period, the plans aim to achieve the following objectives and outcomes:

- Maintain agreed MRD level, to support the delivery of the NHS restoration and recovery plan for elective and cancer care (including reducing cancellations) and support A&E performance
- Improve and sustain improved MRD LOS standards and LOS once a patient has been identified as no longer meeting the Criteria to Reside (in line with the East Sussex Let's Get you Home programme) .
- Support local people to be in the most appropriate place for their care requirements, reducing infection control risks and enabling timely supported discharge from hospital setting that maintains patient independence.
- Enable shift for a proportion of patients from P3 to P1 pathway, further developing the home first approach
- Improve and sustain the agreed maximum time to assessment on D2A pathways
- Define the necessary community capacity and flexibility required to achieve the above
- Overcome or minimise system risks including workforce, surge, covid-19 red/amber.
- Commission and deliver the necessary capacity in a sustainable and affordable way for all whole system partners
- Optimise utilisation of contracted capacity supported by spot purchasing to respond to fluctuations in demand and need
- Provide a sustainable foundation on which to build strategic approaches to developing our hospital discharge model

Our previously agreed target operating model for community health and social care services has been reviewed in light of the learning from delivering the response to COVID-19, with the following areas as the revised priority projects:

- Joint review and development of hospital discharge processes - embedding the hospital discharge hub function in all our hospitals that has been developed as part of the pandemic response, including for out of county acute pathways.
- In the context of the above work, a specific priority is to further support the models and Home First Pathways through developing a multi-disciplinary, integrated urgent response community team to support delivery of Home First Pathway 1 (hospital discharge to own home with a package of support).

4.1 Our approach to improving outcomes for people being discharged from hospital

In addition to the above projects, further exploration and strengthening of the strategic links with the following areas of system work will take place:

- Developing and delivering a system approach to supporting care homes through building on the East Sussex Care Homes Resilience Plan, clinical support offer, champions programme and mutual aid support and the primary care Directed Enhanced Service developments to deliver a cohesive model of support including care at the end of life

- The potential to develop a strategic partnership approach to workforce with Primary Care Networks, community health providers and Adult Social Care relating to allied health professional and other new practitioner roles under the Additional Roles Reimbursement Scheme
- Recovery and supporting the urgent (2 hours and 2 day) response requirements, and also how the community programme supports the recovery of elective care, and the continuing need to deliver services differently as a result of COVID.
- Place based application of programmes being developed across Sussex, for example Ageing Well. To support place level transformation activity and delivery of priorities where programmes benefit from greater scale and being led Sussex-wide.
- Reviewing Home First Pathway 3 (discharge to temporary nursing or residential beds for assessment), across acute and community health and social care processes and a strategic approach to commissioning, procurement and supplier management of beds.
- Within this, shifting Home First pathways and targets, with the capacity and demand modelling and evidenced based decision-making to support this, to arrive at a sustainable model for Discharge to Assess (D2A) within available system resources that best meet the needs of local people.

4.2 How our BCF funded activity supports safe, timely and effective discharge?

A large proportion of current BCF investments directly support safe, timely and effective hospital discharge or admission avoidance including:

- Bed-based intermediate care at Milton Grange – provides step down reablement support for those who require this before returning home.
- Joint Community Rehabilitation: provides reablement to people in their own homes
- Crisis Response: whilst this service was initially commissioned to provide this service provides a 2-hour response to support admission avoidance, it has been expanded to provide support to people following hospital discharge.
- Discharge to Assess beds: purchase of community bedded capacity
- Community Equipment – provides community equipment and minor adaptations to people in their own homes or within care to support safer independent living
- Assisted Hospital Discharge Service: discharge support provided by the voluntary sector
- The Housing OT service aligned to the District and Borough Councils' Housing departments

In addition, it has been agreed for £1.2m from the uplift in 2021/22 allocations to be invested in additional domiciliary care capacity, providing urgent additional homecare and reablement capacity for patients after discharge

5. Disabled Facilities Grant (DFG) and wider services

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

The Housing OT service enables an integrated approach to improved housing solutions and home adaptations to East Sussex residents. It is aligned to the District and Borough Councils' Housing departments to promote the prevention of ill health (falls), avoidable hospital admissions, improve hospital discharges, reduce residential / nursing home admissions and to promote quality of life and wellbeing through major and minor home adaptations.
This has enabled the D&Bs to provide home adaptations at the earliest point of contact, ensure that local needs are appropriately met, and a more seamless service is experienced by people with disabilities in respect of their housing and other social care needs.

6. Equality and health inequalities.

In response to our population needs and associated health inequalities the East Sussex Health and Care Partnership is developing its roadmap for integration which incorporates a refreshed focus on how we approach health and wellbeing and health inequalities in our work. This includes transforming the way we work in East Sussex and promoting wider integrated working in our communities between the health and social care system and the full range of services that impact on the broader determinants of health and reduce health inequalities, including housing, employment, welfare, transport, environment and leisure and voluntary, community and social enterprise sector (VCSE) services and support, by:

- Streamlining and integrated 'wrap around' care and support to high risk vulnerable people who have long term conditions and complex care needs
- Enabling a more targeted approach to populations to support anticipatory, preventative models of care and more long-term action to impact on health inequalities
- Supporting broader social and economic development

We will develop and deliver this agenda in collaboration with local people and key partners, including upper and lower tier local authorities and VCSE organisations, to support prevention and promote health wellbeing in communities in East Sussex. This will include working together to further develop our agreed shared outcomes.

Our shared outcomes from people of all ages in East Sussex:

Population health and wellbeing

The impact of services on the health of the population such as preventing premature death and overall prevalence of disease.

Ambition	Outcome
Improve and protect mental and physical health and wellbeing for local people	• Children have a good start in life • People are able to live well • People age well • People have a good end of life
Reduce health inequalities for local people	• The gap in health outcomes is improved

The experience of local people

The experience people have of their health and care services.

Ambition	Outcome
Good communication and access to information for local people	• Jargon free health and social care information can be found in a range of formats and locations • Health and care services talk to each other so that people receive seamless services and people and staff have access to shared and integrated information
Put people in control of their health and care	• People feel respected and able to make informed choices about services • People have choice and control over services and how they are delivered

Transforming services for sustainability

The way health, mental health, social care, education, housing and other services and support work together, and how effective they are at impacting positively on the people who use them.

Ambition	Outcome
Prioritise prevention, early intervention, self-care and self-management	• People get support from their communities to prevent, reduce or delay their need for health, care and support • People get help early to prevent situations from getting worse • People get help to manage their condition(s)
Deliver an integrated model of care	• People are supported to be as independent as possible
Demonstrate financial and system sustainability	• People have access to timely and responsive care, including access to emergency hospital services when they need them • Financial balance is achieved across the health and care system • Digital services and innovation are used to help make best use of resources

Quality care and support

Making sure we have safe and effective care and support.

Ambition	Outcome
Provide safe, effective and high-quality care and support	• People receive high quality care and support • People are kept safe and free from avoidable harm
Deliver personalised care through integrated and skilled service provision	• People are supported by skilled staff, delivering holistic and personalised care

There are actions set out in our place-based plan that are aimed at directly addressing the known physiological causes of ill health and premature death, across circulatory disease, cancer, respiratory disease, digestive disease, and physical health checks for people with mental health difficulties and people with learning disabilities. Our existing partnership plans and work to support individuals and populations to adopt healthy behaviours around weight, smoking and reducing alcohol harm have been updated and will be implemented during 2021/22.

6.1 Changes from previous BCF plan.

Key achievements in 20/21:

In East Sussex we have:

✓ An existing health inequalities programme established in 2014 to target the eight most deprived wards in the county. The Healthy Hastings and Rother programme, partially funded via the BCF, delivers a broad range of commissioned projects co-designed with partners aimed at reducing health inequalities by improving the health and wellbeing of people in most disadvantaged communities.

✓ Worked with statutory and voluntary sector partners to ensure that people affected by the pandemic who need extra support to cope, including people registered as clinically extremely vulnerable to coronavirus get the help they need such as help shopping for food and essentials.

✓ Supported development of the Rough Sleepers Initiative (RSI) and multi-disciplinary team to improve access to health care and delivered the national 'Care and Protect' model to make sure we can care for people with symptoms and provide the greatest level of protection for those at the highest risk.

✓ Free, confidential support and advice available through our East Sussex Welfare Benefits Helpline for people who are facing financial difficulty, struggling to pay bills or concerned about growing debt, whether this is due to the Covid-19 pandemic or otherwise.

✓ Facilitated joint working between the acute hospitals and voluntary and community sector organisations such as Hastings HEART to utilise support from local volunteers to extend the current hospital discharge pathways into community and take pressure off health and care systems.
✓ Completed the first phase of a hospital discharge wellbeing checks pilot commissioned from Healthwatch East Sussex. 1,441 follow-up wellbeing checks were completed in a four-month period identifying people who needed additional support need and providing signposting to appropriate health, care and community organisations.

Key highlights:

- Development of COVID-19 community hubs in each district and borough to ensure that no one is left without support.
- Secured £3,208,194 in annual benefit payments for people from April to December 2020 with 75% of people living in the most deprived wards in the county and 79% of people surveyed reporting improved mental wellbeing.
- Worked collaboratively with the Police and Crime Commissioner, East Sussex Healthcare Trust and CGL to fund a hospital-based Independent Adviser for Domestic violence and Abuse since September 2020.
- Adapted the parenting support programme delivery model in response to the pandemic and extended its reach to support parents across East Sussex.
- Offered payment incentives to GP practices to deliver health checks to BAME patients, those with a serious mental illness or learning disability, and current smokers.
- Supported a range of programmes led by system partners which aim to address the wider determinants of health. For example CHART (Connecting Hastings and Rother Together) which aims to stimulate local economic growth and improve employability skills and job opportunities, and the Hastings Opportunity Area which is focused on improving social mobility amongst young people and protecting their emotional wellbeing and mental health.

6.2 How health inequalities are being addressed through the BCF plan and services funded through this.

Due to the scope of the transformation required to support improving population health and reducing health inequalities, as it relates to our diverse communities in East Sussex, we have agreed to progress the following linked elements in 2021/22:

An independent organisation has been appointed to undertake initial engagement with stakeholders to inform how we shape and agree our vision and onward actions for:

- *Developing our long-term partnership approaches to community wellbeing building on the successful and rapid introduction of Community Hubs in East Sussex to support vulnerable local people during the pandemic and developing a sustainable model for enabling a joined-up offer across the wider*

services delivered in partnership with District and Borough Councils and the VCSE sector.

- *Developing a systems approach to tackling loneliness and social isolation; the first phase of which will be working with people and partners across East Sussex to launch a 'Connection Campaign' to bring people together to explore how communities across East Sussex can become more connected, and how partners can work better together to enable this*

Primary care developments and Primary Care Network delivery, for example supporting the growth of Population Health Management (PHM) capability, anticipatory care, multi-disciplinary team working and care coordination. This will include engagement of personalised care roles within PCNs - social prescribing link workers, health and wellbeing coaches, and care coordinators - to ensure that personalised care approaches are taken forward. Our Hastings and St Leonards PCN is part of the Sussex PHM Accelerator programme as a PCN pilot. The initial accelerator programme concludes in August 2021 and we will feed this into our local place plans and development.

Further developing the East Sussex social prescribing model, and exploring the potential alignment of other existing commissioned services that focus on health and wellbeing and the social and economic determinants of health

All local plans and programmes will have a focus on health inequalities and will have specific health inequalities priorities developed as part of this that are integral to our objectives. We will also agree our approach to refining our understanding of population health and health inequalities at a geographical level within our communities, to enable support to be more targeted and baselines to be set for reducing gaps in life expectancy and healthy life expectancy and agreeing the approach to measuring impacts over the short, medium and long term.

Personalised care and support approaches will be embedded in all transformation and development as appropriate across specific conditions and care pathways where there are opportunities for personalised care and support planning (including personal health and social care budgets where relevant), social prescribing and asset-based approaches, shared decision-making and supported self-management.

We will also explore ways to join up our approach as employers and service providers at scale within the county for the benefit of the broader social and economic wellbeing of our communities.

A strategic development framework has been produced and agreed by our Health and Wellbeing Board to support and coordinate delivery of progress in all these areas in 2021/22, and aid further planning for 2022/23. This will be underpinned by our shared communications and engagement framework to ensure plans are co-produced with communities and wider stakeholders.

The wide range of services delivered via the BCF in East Sussex support population health and address health inequalities. Examples include:

- Long-term condition management such as education and support for people living with Diabetes
- Reablement opportunities, bed-based and on a domiciliary basis
- Carer support services
- Services to help marginalised people achieve personal growth and fulfilment such as the Seaview project.
- Welfare Benefits support: Free, confidential support and advice available for people who are facing financial difficulty, struggling to pay bills or concerned about growing debt, whether this is due to the Covid-19 pandemic or otherwise.

7. Further References

East Sussex Health and Care Partnership Plan 2021/22
Appendix 1_Draft Summary East Sussex Health and Care Partnership Plan 2021_22.pdf

Sussex NHS Commissioners: Tackling Health Inequalities Progress Report 2020/21 & Action Plan 2021/22
PowerPoint Presentation (eastsussexccg.nhs.uk)

East Sussex 18-month Hospital Discharge Demand and Capacity Plan October 2021 to March 2023

East Sussex Health and Social Care Plan - Equality and Health Inequality Impact Assessment (EHIA) HIGH LEVEL REVIEW