West Sussex Better Care Fund

Narrative Plan 2017-19

Version	Sign Off	Date
Final	11.09.17	11.09.17
0.22	JCSG	29.08.17
0.22	HWBB	29.08.17
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Final	Submitted to NHSE	11.09.17
Revised Plan	NHSE	02.11.17

Table of Contents

Introduction/Foreword

Better Care Vision across Health and Social Care

Introduction/Foreword

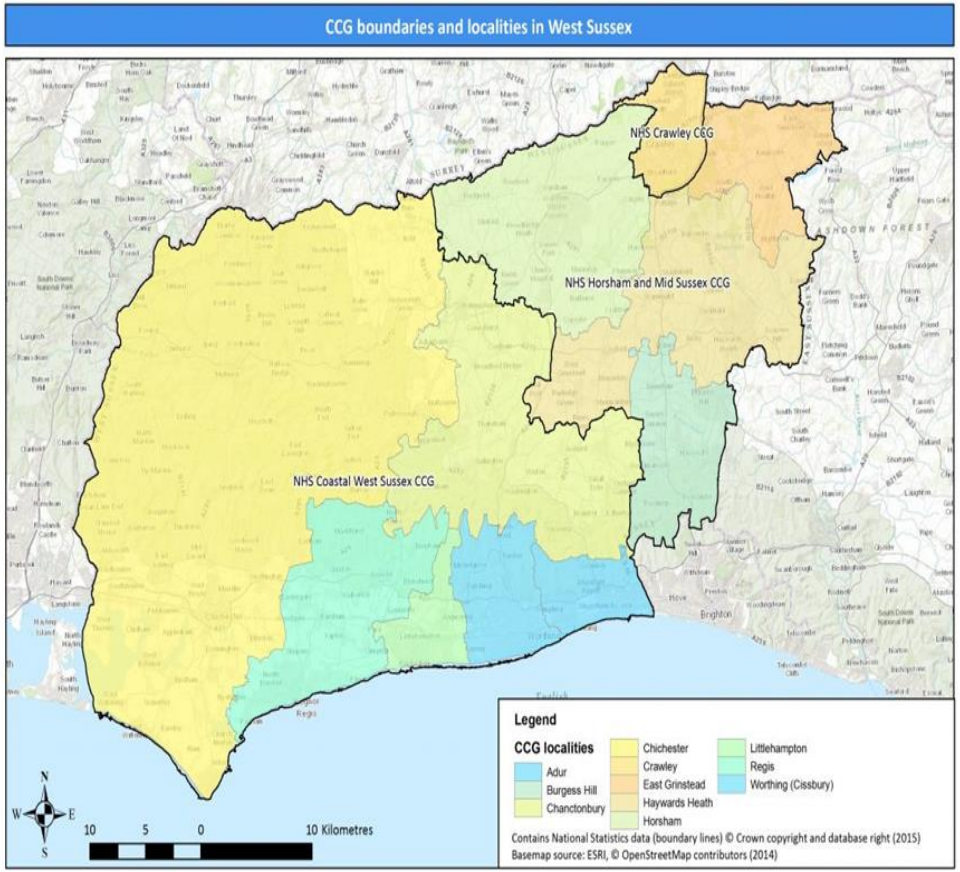
The West Sussex Better Care Fund footprint is a partnership across Coastal West Sussex Clinical Commissioning Group, Crawley Clinical Commissioning Group, Horsham and Mid Sussex Clinical Commissioning Group and West Sussex County Council.

Funding Contributions:

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution excluding iBCF	£8,956,729	£9,568,014
Total iBCF Contribution	£11,358,285	£14,430,380
Total Minimum CCG Contribution	£53,265,733	£54,277,782
Total Additional CCG Contribution	0	0
Total BCF Pooled Budget	**£73,580,747**	**£78,276,176**

Signatories

West Sussex Heath and Wellbeing Board Chairman and members sign off
Coastal West Sussex CCG Accountable Officer
Horsham and Mid Sussex CCG and Crawley CCG Accountable Officer:
West Sussex County Council Executive Director Children, Adults, Families, Health & Education



What is the local vision and approach for health and social care integration?

West Sussex Vision for Health and Care Services

The vision for 2019/20 remains a shift from reactive to proactive health and social care to enable more people to have healthier, safer and more independent lives in their own home and community for longer, receiving the right care in the right place at the right time.

A focus on ensuring more people are able to self-care and, through earlier interventions and preventative services, people will have received treatment or care earlier in their condition or problem. People's mental health as well as physical health will be supported, particularly those people with dementia and people with co-morbidities.

A proactive approach to the provision of health and social care and support in the community to be delivered in partnership through GP practices, integrated health and social care multi-disciplinary teams, community based health and social care services and co-located specialist services.

Delivery of good quality crisis and urgent care in the community, preventing unnecessary hospital admissions by developing additional health and social care and support capacity seven days a week, particularly around hospital avoidance and discharge services.

We understand that without the support of carers, the local health and social care system will face an increasing demand for services. We will therefore continue to invest in services for carers to ensure that they are able to maintain their own health and wellbeing and will also consider how we can support carers better when they or the cared for person, faces a crisis or requires a stay in hospital.

Connected information systems will ensure a smoother journey for the patient through health and social care systems, with technology and risk stratification used to ensure that patients/customers will be proactively supported and receive earlier interventions and/or more targeted treatment or care.

The 2017-19 plan builds on the work already commenced and is embedded across health and social care systems.

West Sussex 's focus is on improving the health and wellbeing of our populations by:

- Delivering preventative and pro-active care, to help people keep themselves well and encourage access to services which improve their wellbeing.
- Strengthening the way we work in our communities, to deliver new models of care which are better able to meet their health, social and wellbeing needs.
- Integrating health, social care and voluntary sector services, to provide better joined up care and support across the services we commission.
- Improving our pathways of care, to deliver better clinical outcomes and choice for patients, and improve the overall patient experience.
- Providing more integrated urgent care in our communities, so that people can be treated locally, do not have to travel to hospital unless it is clinically necessary, and be discharged in a timely manner.
- Achieving the national standards (parity of esteem) across our mental health services, to deliver the new access standards, diagnosis rates for dementia and transform care for people with learning difficulties.

The West Sussex Better Care Fund programme will be aligned to three core areas of work:

- Crisis management
- Long term conditions
- Prevention

This aligns to a strategic direction addressing a frailty plan overall without age boundaries.

Wider System Transformation

The Sussex and East Surrey Sustainability and Transformation Partnership (STP) [1] outlines how the NHS and social care will work together to improve and join-up services to meet the changing needs of all of the people who live in our area.

There are 23 organisations in our partnership; [2] local authorities, providers and clinical commissioning groups. It is the first time that we have all worked together in this way and it gives us an opportunity to bring about significant improvements in health and care over the next five years.

The STP is not one single separate plan. It is a way of making sure that all the plans being developed by the partners across the area are joined up and working together. The STP aims to ensure that no part of the health and care system operates in isolation. We know that what happens in GP surgeries, for example, impacts on social care, which also impacts on hospital wards, and so on.

The STP aims make practical improvements – like making it easier to see a GP, speeding up the diagnosis of cancer, and offering help faster to people with a mental illness. It also aims to support people to take more responsibility for their own health and wellbeing. With services feeling the strain, working together will give our nurses, doctors and care staff the best chance of success.

Our overarching approach is to ensure that there are local 'place based plans' so that people can get the care they need as close to home as possible. Each of the four places is developing its own model of care to meet local needs, but they share the same aims.

The plans will deliver community based, integrated health and care services through 'accountable care systems'. These involve health and care organisations working together to share resources and take joint responsibility not just for treating people but helping them to stay healthy, tailoring their services to the needs of individuals.

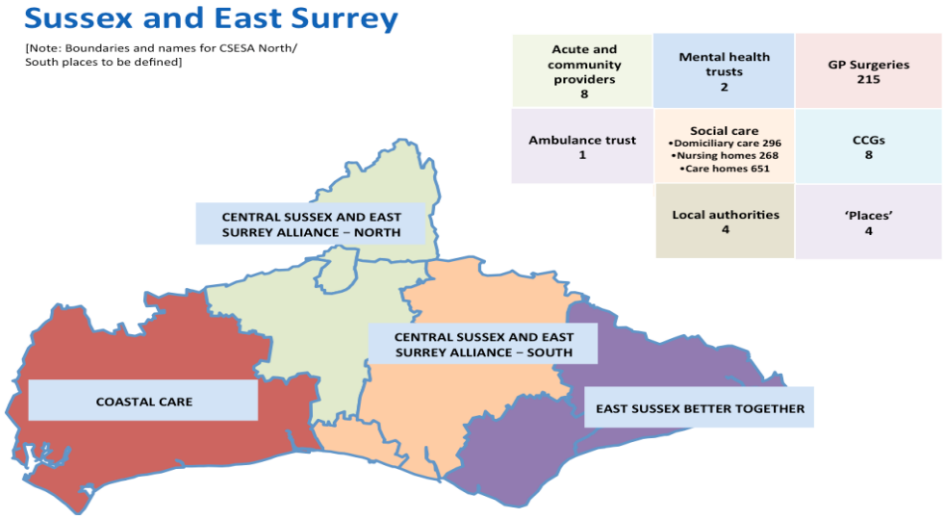
The aims are to:

- Help people to stay well
- Support people to manage existing conditions and retain their independence
- Avoid unnecessary hospital visits

The four place based plans are:

- Coastal Care (Coastal West Sussex) [3]
- Central Sussex and East Surrey Alliance – North [4]
- Central Sussex and East Surrey Alliance – South
- East Sussex Better Together

The place based plans are the cornerstone of the STP and many of the other plans that need to be developed will be shaped around them. They are being developed based on existing and on-going work with local communities.



CSESA

The Central Sussex and East Surrey Alliance (CSESA)[4] will transform the model of commissioning care: from one that is reactive, often crisis-triggered and heavily acute-focused - to one that promotes wellbeing, provides early detection and diagnosis and empowers people to manage their health more effectively within their communities. Primary care will lead the delivery of an effective and sustainable new care model. Practices will work in a more co-ordinated way with each other around natural geographies, embracing a wider skill mix. They will integrate with community health, mental health, social care and voluntary services.

CSESA has set out an ambitious programme to realise fully operational, legal ACS entities by 2020. This will be underpinned by robust benefits realisation of the new care models, delegated population based budgets and reform of the commissioner landscape.

Central Sussex and East Surrey Alliance (CSESA)	
Model	Accountable Care System (ACS)
Vision	To develop proactive, community-centric and more integrated health system, led by primary care that promotes wellbeing, self care and care closer to home
Strategic objectives	• Care designed for the needs of local populations • Successful integration of providers • Sustainability of primary care, acute care, community and mental health care
Initial Priorities	• Improve prevention and self care • Better access to urgent care • Continuity of care for patients with Long Term Conditions (LTCs) • Coordinated care for frail and complex patients • System wide higher quality and performance
Predicted benefits	• Reduction in emergency and planned admissions • More episodes of care in the community • Increased quality of care and patient satisfaction • Stable sustainable workforce • Sustainable primary and acute providers, along with sustainable community, mental health and social care provision • Reduce spend on hospital care by £80m by 2020/21 (12%)

Coastal Care

Coastal West Sussex (CWS) Clinical Commissioning Group[3] are a developing Accountable Care Organisation called Inspiring Healthier Communities Together, Coastal Care. Whilst part of the Sussex Sustainability and Transformation Footprint, this is one of the four Place Based Plans.

Coastal Care aims to bring us a single approach (a common purpose, a single set of objectives and one budget) for the whole population whatever their health or care need, be it:

- generalised or specialist,
- physical or mental,
- adult or child.

It will aim to break down organisational boundaries to create a system where local health and care partners collaborate to resolve the issues for our population and integrate care pathways to be more effective.

Coastal Care should promote physical, mental and social well being by preventing ill health, intervening early and supporting people to better manage their care; a move from reactive to proactive.

Care will be organised around and delivered in partnership with local communities and other agencies.

We believe this will:

- improve standards,
- manage demand and
- make the system financially sustainable.

Coastal Care	
Model	Accountable care model with one capitated budget
Ambition	To take our good care and make it excellent, working together as partners to improve the health and wellbeing of the population. To improve outcomes for individuals and to deliver better value for money
Strategic objectives	• Enhance primary and community care and focus on population wellbeing and early intervention to reduce demand for hospital services • Successful integration of teams and providers
Initial Priorities	• Develop Local Clinical Networks • Tackle the challenge of the ageing population • Redesign urgent care services • Implement new pathways for planned care • Carry out targeted service improvements for children to enhance physical and mental wellbeing
Predicted benefits	• Enhanced primary care • Sustainable community, mental health and social care provision • Improved access to specialist expertise • Communities engaged and developed • Reduce spend on hospital care by £44m by 2020/21 (8%)

Background and Context to the Plan

Better Care Vision across Health and Social Care

Background and Context: Local Need

Together all local partners have considered how the local needs in the context of the Next Steps: Five Year Forward View (NHS England, 2017) will be met. In addition as part of the Sustainability and Transformation Plan, all CCGs are working with health and social care partners in Sussex and East Surrey to tackle these issues collectively, and deliver the triple aim of; Transformed quality of care; Improved health and wellbeing; and Sustainable finances.

Our vision for the BCF, therefore builds on the assessed local needs as advised by the recommendations of the Joint Strategic Needs Assessment (JSNA) [5] produced by West Sussex County Council, national and pathway-specific benchmarking tools and good practice examples such as the Atlas of Variation, Commissioning for Value packs, and Right Care CCG packs[6]. Any plan for the redesign of care pathways will be then shaped by the needs of the population, and what local people, patients and partners tell us about through our communication and engagement with them.

The West Sussex Health Profile 2017[7] profiles key statistics and population details**.**

- **Demographics:** The population of West Sussex is growing with an expected overall increase of 8% by 2020 but with far higher increases for older age groups with increasing need for personal and social care.
- **Life Expectancy:** Although life expectancy in the county is above the national average the rate of increase is slower in deprived communities.
- **Deprivation:** Although a county of relevant affluence, West Sussex has pockets of significant deprivation in Crawley, along the coastal strip, and in a number of rural pockets, with associated health inequalities.

Mental Health: Although the prevalence of mental health conditions is broadly in line with national averages, demand for specialist mental health provision has increased.

West Sussex County Council[8] is facing unprecedented growth in demand for adult social care due to increasing numbers aged between 75 to 84 and at 85+. It is forecast that the number of people eligible for social care will continue to increase to over 8,600 by 2020/21.

Increasing life expectancy means that more people are living with more complex conditions, increasing cost pressures across all care groups. In West Sussex[9] the number of people with 3+ long term conditions will rise from 4,100 to 10,000 by 2029.

Long-term Conditions (LTCs) : With an increasing number of older people within the county, the prevalence of physical and sensory impairment, dementia and multiple long-term conditions will increase. Key areas of prevention and early intervention for West Sussex [8b] include:

- An increasing prevalence of diabetes (currently 6%)
- An estimated 15% to 30% of dementia linked to preventable cardiovascular health problems
- 1 in 10 surveyed respondents with LTCs saying they did not have enough support to manage their conditions
- A comparison of estimated prevalence with recorded prevalence indicating the likelihood of currently undiagnosed people with LTCs presenting at late stage or as an emergency
- Life expectancy is 7.7 years lower for men and 6.0 years lower for women in the most deprived areas of West Sussex than in the least deprived areas

Evidence base and local priorities to support integration/Progress to date

Better Care Vision across Health and Social Care

West Sussex Review (1)

The BCF has been used for genuine transformation of the health and social care systems in West Sussex, in order to meet the combined challenges of the demands of a growing older population and reducing budgets. This transformation means health and social care services consistently provide people with the right care, in the right place, at the right time and with care that is planned and tailored to individual capabilities and needs. The system continues to strive to deliver recognisable changes, by working in partnership with all stakeholders. As a health and social care system we are looking at continuous improvement and ensure transparency and value for money against the pooled fund.

Overall funding levels for continued schemes have remained at the same allocations as 2016/17, enabling stability in schemes across the health and social care system. The remaining pooled fund has been focused on the expansion of schemes for 2017/18 and 2018/19, with a strong emphasis on supporting a reduction in delayed transfers of care and reducing the need for unplanned hospital admissions, and maintaining social care services.

All health and social care partners will build on established joint working relationships and management of health and social care systems, in order that agreed system strategies, planning and priorities are joined up, the impact of improvement is maximised and risk is effectively managed, with BCF being fully embedded in CCG Operational Plans. [10]

West Sussex Better Care Fund[11], continues to work with all commissioning partners to design, develop and agree the joint programme of work to deliver better outcomes for patients, and improve services. The established BCF PMO/Co-ordination team remains in place, hosted by HMS CCG.

The BCF PMO works across the joint commissioning agenda and monitors schemes within the BCF Programme, reporting by exception to the JCSG. Equality Impact Assessments are requested and monitored as part of the BCF PMO approach.

Methods utilised to evidence clear lines of accountability, and the requirement for schemes to evidence improved outcomes include:

- Applying the Self Assessment Toolkit as a survey for key stakeholders to evaluate schemes funded through the BCF which stimulates discussion and challenge
- Monthly Performance and Finance Report and a supplementary DToC Report published for Joint Commissioning Strategy Group (JCSG)
- Internal audit undertaken in August 2016, to ensure the on-going effectiveness of the Better Care Fund
- Applied the Logic Model methodology to current and potential new schemes to identify gaps in measures and ensure links to the core BCF metrics and support benefits realisation
- Undertook Star Chamber style events for all schemes to consider their impact and to ensure there remains maximum efficiencies in delivery, interoperability and ensuring quality services and improved outcomes, and value for money
- Using the results from these initiatives to have the challenging conversations

West Sussex have been involved in the national support offer through jointly delivering the Measuring Success Masterclasses [12]; and national Webinar[13], and through engagement with the Social Care institute of Excellence (SCIE)[14]. Local Partnerships completed a review of our approach to Monitoring and Evaluation[15] with the following conclusions:

- West Sussex BCF Programme has developed a comprehensive and systematic framework for the monitoring and evaluation of the schemes within their BCF Programme.
- The underlying principles and approach reflects the key components that have been identified as ‘good practice’.
- All BCF schemes are included within the process of monitoring and evaluation. The development of a set of clear templates and report formats promotes consistency and transparency across the BCF programme.

West Sussex Review (2)

Develop delivery of seven day services across health and social care:

West Sussex are delivering 7-day services across health and social care under the Sussex & East Surrey Sustainability & Transformation Plan as part of 'Place based transformation' introducing new primary and community urgent care models, and the 'Whole system; acute recovery plan' designed to improve quality and performance. However further work is required. The CCGs continue to work with stakeholders and providers to develop the Operational Winter Resilience Plans[16] in line with NHS England's requirements which includes 7-day working as required by national policy. This work is also identified as an area of focus through the High Impact Change Model[17] self assessments.

Under the Better Care Plan, integrated multi-disciplinary teams continue to provide risk-stratified proactive care, and the continued implementation of an integrated discharge model across the area will formalise the current arrangements that are in existence across West Sussex and ensure the key linkages are made to deliver equitable and accessible 7 day services upon discharge.[18]

Improve data sharing between health and social care:

West Sussex County Council has made further progress in 2016/17 toward resolving the issues which have prevented the acquisition and use of NHS numbers for social care data. The most significant hurdles have been overcome and WSCC is confident that the remaining issues can and will be resolved.

The Digital Roadmap[19] for the Sussex and East Surrey STP proposed an Integrated Digital Care Record as part of the 2016 submission to NHS England. It would constitute a single system that brings together data from several disparate systems and presents it in a manner that is useful to clinicians, practitioners and citizens. Typical deployments can add value to almost any care setting, with particular focus on MDTs, A&E triage (and most acute wards) and 111.

An early IDCR prototype - ROCI (Read Only Care Information) allows clinicians and social care faster access to patient records held by other professionals treating the same individual although this prototype has had slow uptake by clinicians due to a range of mostly non-technical issues. However, an upgraded WSCC system, which went live at the end of July 2017, affords greater opportunity for sharing data or system access than did its predecessor (and user access is already offered in several NHS settings). WSCC therefore expects to be able to integrate with whichever IDCRs emerge in our region, without being driven by any particular organisational model.

The STP Digital Roadmap also articulates a desire to deliver seamless network connectivity between health and social care organisations in the South East of England, unshackling staff from organisational or functional boundaries. A first step in this is to offer shared wireless networking capability across WSCC and some local NHS trust buildings. A WSCC-led project is already underway to deliver this.

There continues to be well developed Information Governance arrangements and data sharing agreements in place supported by and overseen by the Commissioning Support Unit (CSU), and through WSCC Information Governance arrangements.

Ensure a joint approach to assessments and care planning:

West Sussex continues to pursue an integrated and proactive approach [20] to planning and managing care with health and care professionals ensuring that, for integrated packages of care, there is a joint approach to assessments[21] and an accountable professional. This is alongside discharge planning and trusted assessor models developed across all three acute systems in West Sussex.

There is a continued focus on older people with more than one long term condition who are at high risk (65-85%) of hospital admission along with dementia services. Work continues on completing the integration of social care data into the risk stratification tool ARETEMUS 2, used in two out of the three CCG areas, subject to resolution of system issues, with the inclusion of mental health data in-progress, and the ambition to add community data in the current year.

Better Care Fund Plan: 2017-19 Schemes

Continuation of current schemes and new Improved Better Care Fund (iBCF) Schemes

iBCF and High Impact Change Model

The Health and Wellbeing Board (HWBB) is fully engaged in the development and monitoring of the plans, with the Joint Commissioning Strategy Group (JCSG) overseeing and assuring delivery. These arrangements compliment local priorities and delivery plans across health and social care. Accident and Emergency Delivery Boards (A&EDB) are engaged across the county focusing on system flow and improved pathways for discharge.

To meet the revised set of National Conditions, health and social care partners will continue to work across health and social care systems to support the development of out of hospital services; with a clear, focused approach to managing delayed transfers of care, including locally agreed targets. By working collaboratively, health and social care partners will seek improved outcomes for the patients and residents of West Sussex.

West Sussex County Council is facing unprecedented growth in demand for adult social care due to increasing numbers aged between 75 to 84 and at 85+. Over the last 2 years average weekly placement costs for older people's residential care have risen by 10% and average non-residential package costs have been greater at 15%.

The areas of spend for the iBCF funding include:

(1) sustaining and meeting adult social care needs through provision for additional packages of care to meet increased demographic and complexity demand

(2) investing in services (for example reablement, Discharge To Assess, in-house services) to improve discharges and system patient flow

(3) stabilising the market through review of, and increased spend on, care at home and home care services including workforce development through targeted campaigns

(4) investment in preventative services including Technology Enabled Lives and support for mental health / substance misuse and learning disability services

High Impact Change Model (HICM)[17]

The system undertook a series of workshops with health commissioners and providers in June, to self-assess each acute system against the High Impact Change Model. These workshops supported the identification of social care gaps and/or areas requiring increased investment. Plans are being developed, with all partners within the three Acute systems, to see how West Sussex iBCF funding, along with other available funding, for example Integration and BCF funding (including Out of Hospital Commissioned Services funding) and Resilience Funding, can be spent to contribute to system improvements in line with the eight HICM development areas. The HICM change / spending plans, is part of overall iBCF spending plans, which has been finalised and agreed between WSCC and the 3 CCGs in West Sussex.

Proposed schemes and services have been grouped under these areas and include a focus on implementing the High Impact Change Model through system resilience; discharge to assess; development of demand and capacity plan and Trusted Assessor.

This aligns to the section on meeting National Condition Four : Managing Transfers of Care.

2017-19 Funded Schemes

Area	Scheme Name	Funding 2017/18	Funding 2018/19
iBCF	Meeting adult social care needs	£1,400,000	£2,800,000
iBCF	Reducing pressure on the NHS, including supporting more people to be discharged from hospital when ready	£5,858,285	£6,230,380
iBCF	Ensuring that the local social care provider market is supported	£4,100,000	£5,400,000
Crisis Management	Protecting Social Care Services	£16,500,000	£16,500,000
	Reablement	£4,097,000	£4,097,000
	Care Act Initiatives	£2,017,000	£2,017,000
	Integrated Hospital Discharge	£450,000	£600,000
	Total	**£34,422,285**	**£37,644,380**
Proactively managing Long term Conditions in partnership	Disabled Facilities Grant	£7,078,429	£7,689,714
	Proactive Care	£6,383,000	£6,383,000
	Carers Health Team	£276,000	£276,000
	Communities of Practice	£4,379,423	£4,662,577
	Falls (South)	£165,000	£165,000
	Falls (North)	£105,000	£105,000
	Dementia	£100,000	£100,000
	WSCC Carers Initiatives: Assessment, Advice, Support	£3,198,300	£3,198,300
	Carers Support in Hospitals	£225,000	£225,000
	Managing delayed transfers of care initiatives	£0	£329,788
	Total	**£21,910,152**	**£23,134,379**
Prevention	Improving Quality in Care Homes: Firefly	£35,000	£35,000
	Telecare	£300,000	£300,000
	Community Equipment	£650,000	£650,000
	Social Care Reablement	£420,000	£420,000
	Wolfson	£100,000	-
	Total	**£1,505,000**	**£1,405,000**
Enabler	Better Care Fund Programme Support	£180,000	£180,000
	Programme Support Care Homes	£35,000	£65,000
	Mandated Social care uplift requirement 1.79% and 1.9% to be allocated to schemes	£391,699	£423,211
	Total	**£606,699**	**£668,211**
	TOTAL COMMITTED FUNDING SCHEMES	**£58,444,136**	**£62,851,970**

2017-19 Scheme Overview (1)

DISABLED FACILITIES GRANT (DFG)[22]:
To provide for adaptations to a disabled persons property that are both necessary and appropriate for the needs of the disabled person and reasonable and practicable in relation to the property to support individuals across West Sussex to remain independent in their own homes. The DFG allocation is apportioned across seven district and borough council areas. Building on the learning from the Test and Learn [23] pilot of:
The value of:

- One team, one service
- Ownership - case managed approach
- Supporting self funders to self help
- Greater flexibility with pooled budgets, no need for top ups, spend against demand
- A better experience from the customers perspective

MAINTAINING (PROTECTING) SOCIAL CARE SERVICES:
The social care services protected through this committed funding will:

- Provide positive outcomes for people through optimising not only their health and well-being but also their independence
- Contribute to the local transformation and integration of health and social care systems
- Enable social care services to develop in line with the overarching design principles and revised ways of working agreed and expressed in the BCF Plan
- Reduce the need for more costly acute health interventions by supporting people to remain in their own home and in their own community when they:
  - Face a deterioration in their health and / or longer term condition(s)
  - Have a crisis
  - Have a need to be discharged from hospital at a time that is appropriate and in a way that enables them to be supported to remain independent and not require further acute or community health services

PROACTIVE CARE:
To further develop community based integrated teams to offer holistic care to the growing frail elderly population and those with complex needs including long-term conditions; reducing their risk of unplanned hospital admission.

COMMUNITIES OF PRACTICE:
To further develop community based integrated teams to offer holistic care to the growing frail elderly population and those with complex needs including long-term conditions; reducing their risk of unplanned hospital admission. To develop the use of community paramedics to develop town based networked paramedic practitioner model; and Town based networked Extensivist model /Extended frailty practitioner roles to support COP.

REABLEMENT:
Reablement aims to reduce / prevent hospital admissions. Reablement is key in the prevention agenda and seeks to help people maintain independence for as long as possible.

CARERS ADVICE SUPPORT, ADVICE AND INFORMATION:
To ensure Carers feel less isolated, stay mentally and physically fit and maintain their wellbeing and life outside the carer role. This includes services for County wide carers information, advice assessment and support; Short breaks; Carers Health and Wellbeing Fund; and Assistive Technologies Fund.

CARERS SUPPORT IN HOSPITALS:
To ensure Carers feel less isolated, stay mentally and physically fit and maintain their wellbeing and life outside the carer role.

CARERS HEALTH TEAM:
To ensure Carers feel less isolated, stay mentally and physically fit and maintain their wellbeing and life outside the carer role.

2017-19 Scheme Overview (2)

TELECARE:
To drive the adoption of technologies which assist delivery of health and social care and to develop a culture where Assistive Technology is the primary consideration by members of the public and health and social care professionals.

COMMUNITY EQUIPMENT:
To enable people with increasingly complex needs to remain in their own home and to support new models of community based health care.

SOCIAL CARE REABLEMENT SUPPORT SERVICE
To support and to maximise the effectiveness and value of reablement support to prevent customers from needing to receive additional and/or more intensive health and social care services.

IMPROVING QUALITY IN CARE HOMES: FIREFLY
Firefly, through its data intelligence and algorithmic capability, will grow to be a key tool for monitoring the state of the market and for strategic decision making.

CARE ACT INITIATIVES:
To support the implementation of the new duties for Local Authorities to be brought in under The Care Act.

BETTER CARE FUND PROGRAMME SUPPORT:
To enable agreed transformational programme work to be funded.

INTEGRATED HOSPITAL DISCHARGE:
To develop a longer term high level Target Operating Model developed through joint working, focused on a flexible and seamless response across the end to end system, for integrated hospital discharge across the Coastal West Sussex health and social care system. Reviewing Front and Back Door within acutes and through targeted integrated seven day working and trusted assessor.

FALLS:
Assessing needs and gaps for Falls Prevention Services across West Sussex and the identification of the potential capacity that needs to be found. By tailoring the approach to Falls according to both the Falls Risk Assessment Tool (FRAT) score as well as Patient Activation Measure (PAM) - this will direct patients to the appropriate level of Service according to both their Clinical need as well as ability to self manage. This is delivered across two separate schemes coordinated by the CCGs.

DEMENTIA:
Support to provide equity of access across the County for the Memory Assessment Service, so that people with dementia are diagnosed as early as possible, and are able to receive appropriate support and services.

CARE HOMES PROGRAMME SUPPORT:
Programme Management support to map and implement improved joint commissioning across West Sussex.

WOLFSON:
Funding to support a pilot initiative of telecare and telehealth in care homes aligned to charitable funding through Wolfson. West Sussex Digital Health Project is a new programme to help improve the care of your patients living in care homes, or those with long-term conditions who are receiving regular care and support in their own homes.

MANAGING DELAYED TRANSFERS OF CARE INITIATIVES:
A range of services to underpin managing transfers of care, which may include equipment provision and programme support for scheme implementation.

MANDATED UPLIFT FOR SOCIAL CARE OF 1.79% IN 2017/18 AND 1.9% IN 2018/19
System developments agreed between social care and health for the mandated social care uplift.

Meeting the National Conditions

1. Plans to be jointly agreed

Plans to be jointly agreed

The 2017-19 Better Care Fund Narrative Plan has been developed jointly with all key stakeholders and agreed through the governance structures within the organisations and through the Health and Wellbeing Board (HWBB).

A refreshed Section 75 agreement is being developed to capture the changes in national conditions, iBCF and new schemes for 2017-19 .

A focus is to address future capacity and workforce requirements across the system aligned with the HWBB strategy. The outcome sought is for a vibrant and motivated workforce with the right training and the right values to support a high quality health and care system.

As part of the robust monitoring arrangements in place for evaluating the effectiveness and impact of all funded schemes, JCSG are committed to implementing the recommendations from the Local Partnerships review.

These include:

- A data mapping exercise to be undertaken to identify and clarify the required data sources and data flows into the programme in support of effective monitoring and evaluation of BCF schemes.
- Addressing any gaps in scheme metrics with analysis and reporting to follow the agreed templates and protocol set out for monthly 2017-19 Programme reporting.
- Improved assessment and reporting of the implications of changes in scheme performance and against agreed targets and/or expectations of ‘effectiveness’ and/or ‘value’.
- Systematic identification of any necessary remedial or other actions that need to be taken in response to the reported level(s) of performance.
- For schemes where there is a need for a greater shared understanding of the way it is expected to contribute to Programme outcomes, undertake a ‘logic modelling’ or similar exercise to help clarify assumptions and identify key scheme metrics.
- Review of current approach to risk assessment and reporting to ensure clear alignment with assessment and scheme performance, whether as part of a composite RAG rating or other.
- Review of the potential to extend the ways that patient/service user feedback is collected and reported into the Programme.

2. Maintain provision of social care services
3. NHS commissioned out-of-hospital services

Maintain provision of social care services (not spending)

Protecting social care means continuing to meet current levels of eligibility to ensure eligible adults who are at risk of harm, abuse or neglect are safe, as well as helping people with long term conditions and/or age related co-morbidities to live independently as long as possible through person centred support.

Adult Services are committed to working jointly and in partnership with health commissioners, health providers and other stakeholders, to look at ways of integrating the commissioning and delivery of health and social care services to:

- support people to remain in their own homes through a health or social care crisis
- support people to not have to be admitted to hospital unless that is the best place for them
- ensure people are only in hospital for as long as is necessary
- support people to return to their own home after being in hospital as soon as it is appropriate and safe for them to do so
- enable people to manage their care and support needs within their own home and community

It is important, though, to see the Better Care Fund funding of £16.5m, which is continuing to be provided for protection of social care services, as helping sustain the wider health and social care system in West Sussex rather than as the source of funding for a narrow list of services

Agreement to invest in NHS commissioned out-of-hospital services

The continuation and expansion of schemes for 2017-19 include integrated hospital discharge to support people from an acute setting and develop further out of hospital services.

Through effective monitoring and reporting through Joint Commissioning Strategy Group (JCSG), there is a clear process for releasing funds held in contingency to invest in NHS commissioned out-of-hospital services.

See section on Risk Share and Contingency

4. Managing Transfers of Care

Managing Transfers of Care

In order to meet the national condition there have been on-going discussions with WSCC, CCGs and providers through the JCSG, local Accident and Emergency Delivery Boards (AEDB) and local discharge groups. In addition a series of workshops with health commissioners and providers were held in June 2017, to self-assess each acute system against the High Impact Change Model, for Surrey and Sussex NHS Hospital Trust (SASH); Brighton and Sussex University Hospital (BSUH) and Western Hospital systems.

The three AEDBs working across West Sussex have put a number of measures in place to ensure the best outcomes for the residents of West Sussex. They seek to ensure operational resilience by:

- Delivering the A&E 4h wait and other emergency metrics
- Delayed Transfers of Care kept at a minimum , supported by robust management process
- Delivering speciality compliant 18 week pathways
- Delivering safe Infection Control Capacity for C Diff /MRSA/D&V
- Deliver timely ambulance handovers
- Ambulance conveyance rates
- Plan and implement SAFER start model at key points after bank holidays or when system pressures escalate
- Daily and weekly focus on DTOCs
- Ensure timely system response with 'triggers' and action as tested by ECIP
- Ensure national definitions used consistently for DTOCs
- Applying the self assessment areas of focus highlighted by implementing the HICM

Across the systems there have been lessons learned including:

- The system's culture has significantly changed and improved over the Winter
- The system has learned and worked together in a much more collaborative approach than previous years
- SHREWD enabled wider system visibility of pressures
- Partnership working during escalation
- Agreement for escalated actions and response from all partners
- Pooled resilience and agreement to focus on the top 5 key priorities
- MADE events have worked well, with involvement from all system partners
- Stronger processes were put in place to increase timely discharges.

Principles:

- Built on system reviews of previous winters, A&E sustainability plans and organisational planning
- Transparency of using lessons learnt into current resilience plans
- Addressing key aspects that create pressure within our local system for admission avoidance or discharge support
- System-wide engagement in developing and agreeing a plan that meets the strategic needs of the local health and social care economy.
- System leadership and decision making form the Local A&E Delivery Boards
- Going into winter the system needs to be working as well as it can be.
- Alignment across Sussex is being progressed with the sharing of surge plans and system learning with Sussex and Surrey leads and links to the Sustainability and Transformation Partnership (STP) planning. This is being taken forward by the place based leaders through the STP executive committee and programme board

4. Managing Transfers of Care (2)

Managing Transfers of Care

Managing the system:

- All stakeholders have been contributing to developing SHREWD and ensuring that triggers for each level of escalation are jointly agreed. This work is informing the Escalation Plan that has been developed.
- The system escalation plan is under review to ensure the triggers are aligned to providing a more pro active response to increasing pressure across the system. These triggers will then be managed by the SHREWD system and key operational leads across the organisations.
- There are daily operational calls across the system throughout the year that allows all community and social care partners to share planned capacity and discharge activity from acute and community teams to ensure we optimise the use of the capacity.
- During periods of pressure the system wide calls are escalated and co ordinated by CCG Exec lead as per the local escalation policy and in line with NHS England OPEL guidance.

Key areas of risk are:

- Increasing older population, higher acuity and complexity
- Significant workforce issues across all providers, particular pressure in nursing, GP and carers
- Fragility in nursing home and domiciliary care markets

The AEDB Winter Plans as submitted to NHSE, detail the activity and areas of focus for each of the three acute systems in West Sussex.

Overview of funding contributions

Overview of funding contributions

The West Sussex Better Care Fund Plan 2017-19 has specific schemes utilising the funding contributions detailed below:

Disabled Facilities Grant

Work is ongoing between the CCGs, district and borough councils and the local authority across West Sussex, to consider how services, including DFG funded home adaptations, and use of technologies can be delivered to ensure a seamless and joined up approach to assessment of need and access to the those services. This work is on-going into 2017/18 and 2018/19 to deliver on the Good Practice Guidance and evidencing Impact and Benefits through:

- ✓ Improved customer experience (flexibility; ease and choice)
- ✓ Reduced end to end times
- ✓ Reduction in costs – getting it right first time for the customer; avoiding rework; designing out the waste in system
- ✓ Improved discharge pathways from hospital – more flexible use of DFG
- ✓ Improved partnership and collaborative working
- ✓ Implementation of appropriate measures to demonstrate impacts and benefits
- ✓ Support people to maintain their home environments to enable them to remain independent in their own homes

The 2017-19 DFG allocations are assigned, as per guidance to the seven district and borough councils; Adur, Arun, Chichester , Crawley Horsham (Inc. Chanctonbury), Mid Sussex ,and Worthing with DFG allocations totalling £7,078,429 in 2017/18 and £7,689,714 in 2018/19.

Care Act Monies

The monies allocated exceed the minimum requirement in the ready reckoner and focus on carers assessments and other initiatives to meet the new statutory requirements and supporting carers across West Sussex.

Carers Breaks [24]

There is dedicated carer-specific support, including carers' breaks, detailed through the schemes and set out in the 2017-19 Better Care Fund Plan, to meet key outcomes including reducing delayed transfers of care and preventing non-elective admissions.

Reablement

The West Sussex BCF Plan continues to include NHS funding to maintain current reablement capacity in councils, community health services, the independent and voluntary sectors to help people regain their independence and reduce the need for on-going care. Funding is also allocated to Social Care Reablement and through Protecting (Maintaining Social Care). A new Reablement service has been tendered during 2017 and is due to become operational in December 2017.
With the CCG's, the Local Authority have been reviewing how these services could be delivered more efficiently through aligning services with health responsive services. In addition the council is developing bed based Reablement schemes.

iBCF

This totals £11,358,285 for 2017/18 and £14,430,380 for 2018/19 and there is a jointly agreed spending plan that focuses on the areas of:

- Meeting adults social care needs
- Reducing pressure on the NHS, including supporting more people to be discharged from hospital when ready
- Ensuring that the local social care provider market is supported

Proposed schemes and services have been grouped under these areas and include a focus on implementing the High Impact Change Model, development of new prevention services, supporting people with dementia, supporting people with life long conditions and workforce development.

Programme Governance

2017/18 and 2018/19 Plans

The Better Care Fund

BCF Governance in West Sussex 2017-2019

The ultimate management of the BCF remains through the West Sussex Health and Wellbeing Board (HWBB), however the HWBB have delegated the management of the delivery of the BCF to the West Sussex Joint Commissioning Strategy Group (JCSG). This comprises key executives from the County Council and the three West Sussex CCGs.

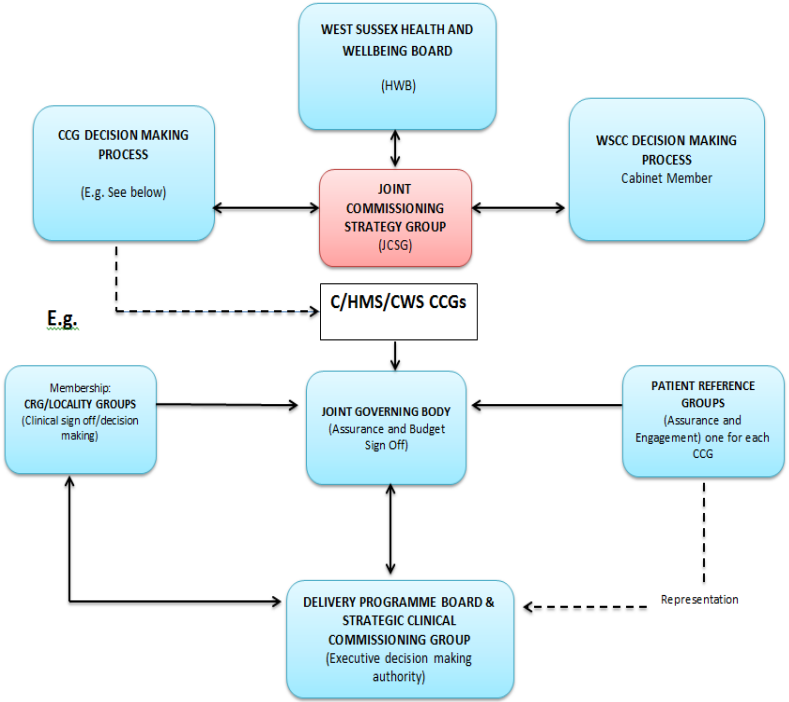
The JCSG provides the forum for the four parties to agree their approach to transforming the health and social care system through joint commissioning, integrated approaches to care and the BCF. The JCSG also monitors progress and expenditure of the BCF and discusses, agrees and manages remedial actions should plans go off track. The JCSG is not separately accountable in itself, with each member organisation having governance and accountability arrangements at individual organisational levels. For WSCC this is currently the Health and Social Care Transformation Board (reporting to WSCC Cabinet as required) and for the CCGs this is their Clinical Cabinets supported through their Local Transformation Boards.

An agreed key principle is that the BCF provides an opportunity and leverage for change, however BCF should not be viewed separately from the whole system context.

As the landscape changes with the formation of new Place Based Plans, the governance arrangements may be refreshed to reflect new reporting systems. This is against the requirement of HWBB's remaining accountable for the Better Care Fund, and against a West Sussex footprint.

Governance under JCSG has been initially reviewed in line with the developing Sustainability Transformation Partnership and sub groups for Finance; Health and Social Care Commissioning and Mental Health/Learning Disability and Children and Young People , have been established, reporting by exception to JCSG. These groups provide additional focus on the joint commissioning agenda and not just activity for the Better Care Fund.

The eight CCGs within the Sussex and East Surrey Sustainability and Transformation Partnership (STP) have been working together to consider the areas in which we can collaborate more effectively, to have a strong commissioning voice on a broader scale, to reduce variation in commissioning outcomes and to create economies of scale through collaboration. This will be driven through the STP Governing Body[25].



Progress on Meeting National Conditions

Meeting Planning Requirements and Key Lines of Enquiry following Assurance

Progress against Planning Requirements

Planning Requirements 4, 11 & 12 – Includes evidence of engagement and discussion with NHSE South East finance colleagues regarding the Non Elective Admissions risk share to confirm achievability and any associated financial risks.

The BCF Coordinator has engaged with the NHSE finance lead via email , telephone and in writing. The CCGs and WSCC have agreed to take forward the agreement of 100% of the NHS Out of Hospital ring fence to be identified as contingency and retained in the first instance by the CCGs. Additional targets have been set to equate to the 100% contingency fund in recognition of the challenging financial constraints facing the local system and the ongoing activity and pressures in the acute system. Through performance monitoring should the targets be met and funding to be released on a quarterly basis the focus will remain on supporting admission avoidance. The full risk sharing agreement will be set out in the refreshed Section 75 agreement and will cover liabilities up to the value of the contingency fund and the BCF committed funding schemes.

Planning Requirements 5 – Includes the High Impact Change (HICM) model self-assessments.

The self assessments have been submitted to NHSE and the Better Care Manager to support the outputs from the HICM workshops.

Planning Requirements 8 – Addresses and demonstrates agreed local benefits realisation of BCF schemes and demonstrates agreement and next steps about how to address underperforming schemes. This could link to previous Better Care Advisor recommendations and report findings.

As part of the governance review across the health and social care system, there is a Health and Wellbeing development workshop in November 2017, working with an external facilitator from the Local Government Association (LGA) utilising the “Stepping Up to the Place Self-Assessment Tool”. The workshop will explore an evidence base of characteristics that local systems need to have to work effectively together and to use that to inform the development of the West Sussex HWBB. The session aims to provide a healthy challenge to our perceptions of progress of our alignment with one another and the work of the Board so far and help us to focus down on the most impactful improvements needed for the Board to enable our health and social care systems as a whole to move forward and to do so at pace.

As the Joint Commissioning Strategy Group (JCSG) is a delegated group of the HWBB, with key members sitting on both groups, the development workshop is an opportunity to set the work programme and ensure the reporting from the JCSG, meets expectations on the Better Care Fund Programme.

Progress against Planning Requirements(2)

Planning Requirements 8 –

As part of the monitoring of the funded schemes through the BCF the scheme leads for committed funded schemes have been contacted by the Executive Director and Accountable Officers across health and social care system.

Joint Commissioning Strategy Group (JCSG) agreed the need to review all existing Better Care Fund (BCF) schemes in order to fully understand:

- the intended intervention that a scheme is funding,
- the key performance indicators that schemes are measuring,
- the data that is being gathered and processed to inform KPIs, and
- the impact that the schemes are having in terms of outcomes achieved against intentions and value for money,

in order to maximise benefits for the system(s) and ensure schemes are fit for purpose to reduce system pressures.

It is proposed to hold a series of workshops with schemes to ensure an effective system of address underperformance in schemes and being able to determine further investment or disinvestment from the Better Care Fund. In addition to fully understand the interventions and activities and these align to the core national metrics in the BCF.

The workshop utilising a Logic Modelling methodology will be tested on 9th November with outputs reported to JCSG for roll out in the coming weeks. The draft slide pack is included below.

Scheme Workshop

This approach has been shared with the Better Care Manager and the Better Care Advisor.

The system has continued the engagement with the Better Care Advisor who will be attending a future JCSG in early 2018 to review the current positon and progress against the recommendations in the BCA evaluation report.

- A data mapping exercise to be undertaken to identify and clarify the required data sources and data flows into the programme in support of effective monitoring and evaluation of BCF schemes.

- The current gaps in scheme metrics to be addressed and analyses and reporting to follow the agreed templates and protocol set out for monthly 2017/18 Programme reporting.

- Improved assessment and reporting of the implications of changes in scheme performance and against agreed targets and/or expectations of ‘effectiveness’ and/or ‘value’.

This includes

- Systematic identification of any necessary remedial or other actions that need to be taken in response to the reported level(s) of performance.
- For schemes where there is a need for a greater shared understanding of the way it is expected to contribute to Programme outcomes, undertake a ‘logic modelling’ or similar exercise to help clarify assumptions and identify key scheme metrics.
- Review of current approach to risk assessment and reporting to ensure clear alignment with assessment and scheme performance, whether as part of a composite RAG rating or other.
- Review of the potential to extend the ways that patient/service user feedback is collected and reported into the Programme

Assessment of Risk and Risk Management

Risks and Risk Share

There are organisational, financial and reputational risks for all organisations within the health and social care system if they are unable to manage system pressures. The County Council has a number of strategic risks detailed in its own Risk Register, as part of the Total Performance Monitor, which can be affected by the effectiveness of schemes put in place to manage these system pressures. This may include the challenge of shaping the health and social care market.

The BCF Coordinator maintains a Programme Risk Register and will monitor and escalate risks to JCSG and HWBB for consideration and action.

The key risks aligned to the Better Care Fund Plan include:

- The increased activity which may prevent evidencing improved outcomes
- The risk of maintaining status quo in services, and not transforming them for real integration by 2020
- Use of the BCF fails to deliver the national conditions and funded schemes lead to an increase in the number of NEA's, DTOCs, admissions to residential care homes
- Impact of the Sustainability Transformations Partnership and Place Based Plans, with different geographical and financial footprints
- The delivery of the Financial recovery plans for CCGs against the requirement of the Better Care Fund minimum contributions

Risk Share/ Contingency

It has been agreed by WSCC and the Clinical Commissioning Groups to ring-fence a proportion of their overall BCF allocation to invest in NHS-Commissioned out of hospital services as determined by the CCG financial allocations. As detailed in National Condition Three the local area has considered holding back part of this ring fenced funding in contingency.

West Sussex Better Care Fund have a local agreement in place for the contingency plan for 100% of the available NHS-Commissioned out of hospital services funds to the CCGs.

This is in recognition of the trend in increased activity in Non Elective Admissions (NEA) across the different systems.

Despite on going work across the health and social care system the reductions planned in NEA were not achieved and activity levels have remained a concern.

- The full risk sharing agreement will be set out in the refreshed Section 75 agreement and will cover liabilities up to the value of the contingency fund and the BCF committed funding schemes.
- The total pooled fund will stand at £73,580,747 in 2017/18 of which £15,136,611 will be the contingency element.
- The total pooled fund will stand at £78,276,176 in 2018/19 of which £15,424,206 will be the contingency element.

Regular monitoring of spend will be through governance arrangements with quarterly reports to HWBB on spend and monthly reporting through JCSG. Investment in NHS commissioned out of hospital services will be developed in year, should additional funds become available. Based on forecast activity this may not be realised in 2017-19.

The planning template details profiled quarterly targets against the 100% contingency plan for NEAs. The value of the contingency fund has been calculated based on the number of additional reductions in non-elective admissions, multiplied by the value of these admissions based on the West Sussex reference cost of £2400.

All schemes will be monitored for their effectiveness and impact and escalated to JCSG.

National Metrics

National Metrics 2017-19

Indicator	2017/18 Target and Rationale	2018/19 Target and Rationale	Commentary
Total Non-elective Admissions (Specific Acute) *(Total non-elective spells in to hospital (specific acutes), all-age, per 100,000 population.)*	**2017/18 Target:** Additional reduction in NEA activity over CCG operating plan assumptions have been planned through BCF aligned to contingency fund expectations. **Rationale:** Local Risk Share agreement/ Contingency arrangement will be in place to address NEA over-activity seen throughout 2016/17.	**2018/19 Target:** Additional reduction in NEA activity over CCG operating plan assumptions have been planned through BCF aligned to contingency fund expectations. **Rationale:** Local Risk Share agreement/ Contingency arrangement will be in place to address NEA over-activity seen throughout 2016/17.	100% contingency has been sought with challenging targets set to reflect the ambition beyond the operational plan reductions in NEAs.
Admissions to Residential and Care Homes *(Long-term support needs of older people (aged 65+ and over) met by admission to residential and nursing care homes, per 100,000 population.)*	**2017/18 Target:** 595.4 **Rationale:** Target reduced from 2016/17 while recognising change in definition from actual recorded admissions to recorded intent of admission.	2018/19 **Target:** 595.1 **Rationale:** Target reduced from 2017/18 recognising change in definition from actual recorded admissions to recorded intent of admission.	Expectation is that through the new pathways for discharge planning, there would be a stabilisation in the number of permanent admissions as alternative options will be available when discharging from hospital.
Effectiveness of Reablement *(Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.)*	**2017/18 Target:** 85.3% **Rationale:** Target is set as an increase against 2016/17 outturn, whilst recognising that the cut-off for reporting is not in line with statutory reporting thereby carrying some risk.	2018/19 **Target:** 86% **Rationale:** Target is set at a 1% increase from 2017/18 whilst recognising that the cut-off for reporting is not in line with statutory reporting thereby carrying some risk.	New contract tendered in 2017 with expectation improved reporting requirements to evidence performance levels.
Delayed Transfers of Care *(Delayed transfers of care from hospital per 100,000 population aged 18+.)*	**2017/18 Target:** 1264.3 **Rationale:** Trajectories for NHS attributed delayed days and Social Care attributed delayed days have been set to meet the September 2017 targets. Jointly attributed delayed days assume maintenance of	**2018/19 Target:** 1173.6 **Rationale:** Trajectories for NHS attributed delayed days and Social Care attributed delayed days have been set to meet the September 2017 targets. Jointly attributed delayed days assume maintenance of	The West Sussex plan for Delayed Transfers of Care aims to maintain the September 2017 targets throughout the remainder of 2017-19 adjusted for population growth. All CCGs mapping on to the HWBB area by 2% or more are included in this trajectory with the assumption that the September 2017 targets are achieved and maintained throughput the period. However, as with previous BCF returns, approval is given by those CCGs

Key Documents

Further information that supports the West Sussex Better Care Fund Plan can be found in the following documentation, and is available on request. Documents are referenced in the narrative plan and aligned to a number detailed here:

[1] STP Sussex file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/STP%2033%20Sussex%20and%20East%20Surrey%20November%202016.pdf

[2] STP Narrative file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/STP%20narrative.pdf

[3] Coastal West Sussex CCG Vision for Integrated Care: https://www.youtube.com/watch?feature=player_embedded&v=a2ItcHwlB04

[4] Central Sussex and East Surrey Alliance (CSESA) Place Based Plan file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/FOR%20SHARING%20161020%20CSESA%20Place%20Based%20Plan%20FINAL.pdf

[5] West Sussex Joint Strategic Need Assessment (JSNA): http://jsna.westsussex.gov.uk/reports/joint-strategic-needs-assessment-report/

[6] CCG Local Area Profiles: http://jsna.westsussex.gov.uk/ccg/ccg-area-profiles-now-live/

[7] West Sussex Health Profile 2017 http://fingertipsreports.phe.org.uk/health-profiles/2017/e10000032.pdf

[8] West Sussex Joint Health and Wellbeing Strategy 2015-2018: http://www2.westsussex.gov.uk/ds/cttee/hwb/hwb050215i6a.pdf

[8b] Future West Sussex Plan 2015-2019: http://www2.westsussex.gov.uk/ds/cttee/cc/cc190216i5a.pdf

[9] Public Health Briefing file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/Public-Health-Briefing-MYE-2016.pdf

[10] 2017-19 Clinical Commissioning Group Operational Plans: NHS Horsham and Mid Sussex CCG, NHS Crawley CCG and Coastal West Sussex CCG

[11] 2016/17 Better Care Fund Plan

[12] Measuring Success Masterclass: http://www.scie.org.uk/files/integrated-health-social-care/better-care/fund-guidance/measuring-success.pdf

[13] Measuring Success Webinar: https://www.youtube.com/watch?v=_f6i2z850Kg

[14] Social Care Institute of Excellence Blog: http://www.scie.org.uk/news/opinions/bcf-west-sussex

[15] Local Partnerships Better Care Support Evaluation Report:

[16] Resilience update for Health and Wellbeing Board file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/hwb131016i7.pdf

Key Documents (2)

Further information that supports the West Sussex Better Care Fund Plan can be found in the following documentation, and is available on request. Documents are referenced in the narrative plan and aligned to a number detailed here:

[17] West Sussex Health & Social Care System Workshop: High Impact Change Model

[18] Report by Adult Social Care on Winter Planning to Health & Adult Social Care Select Committee (HASC):
file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/hasc101116i6.pdf

[19] Digital Roadmap for the Sussex and East Surrey STP:

[20] New Adult Operating model report to HASC:
file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/hasc290916i10pres.pdf

[21] Adult Operations – Future Vision and Operating Model Report to HASC:
file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/hasc290916i10.pdf

[22] Disabled Facilities Grant
file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/ws236_disabled_facilities_grants.pdf

[23] Disabled Facilities Grant Test and Learn Pilot

[24] Carers: Joint Commitment to Carers report
https://www.westsussex.gov.uk/media/6396/joint_commitment_to_carers_report.pdf

[25] STP Governance Paper
file:///V:/USF/West/NWSCA/Delivery%20Team/BCF/BCF%202017-19%20Reference%20Files/Item%205.1%20SES%20STP%20FINAL%20Governance%20Paper.pdf