Brighton & Hove Better Care Fund Plan 2022/2023

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s)

Delegated authority has been given to the Brighton and Hove BCF Steering Group to complete the 2022/23 plans and financial templates with sign off by the Executive Managing Director for Brighton and Hove, NHS Sussex.

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCSE organisations, housing organisations, district councils)

An integrated approach across the NHS, local government and wider voluntary and independent sector services plays a key role in supporting people to manage their own health and wellbeing effectively. At the local level that integration is managed through the Brighton and Hove Better Care Fund Steering Group. This brings together Brighton and Hove City Council, our new NHS Sussex Integrated Care Board.

Plans are promoted for awareness amongst other system partners including University Hospitals Trust NHS Foundation Trust, Sussex Community NHS Foundation Trust and Sussex Partnership NHS Foundation Trust, Southeast Coast Ambulance Service, primary care networks, Healthwatch, the Voluntary, and Community and Social Enterprise (VCSE) organisations.

How have you gone about involving these stakeholders?

The overall purpose of the B&H Health and Care Partnership is to support delivery of our locally agreed plans and programmes of transformation that support the local population health agenda and addresses health inequalities through commissioning an effective, sustainable and aligned health and care system.

Through a partnership approach the B&H Health and Care Partnership has the following key roles:

1. Supporting the ongoing development and implementation of a longer-term integrated local Brighton and Hove Plan which will form part of our Sussex and will form part of the 22/23 ICS Operational plan for Sussex and respond to the NHS Long Term Plan. This will cover physical and mental health services across acute, community and primary care settings, social care, housing, and prevention.

2. Supporting the delivery of initial agreed priority programmes of transformation in core areas of urgent care, planned care, community services, Mental health, and Homelessness.

3. Ensuring engagement with the delivery of the plans we agree, and collectively tackling the issues and challenges we face as a system.

Contents

1. Executive summary

Through 2022/23, and alongside a pan-Sussex review, Brighton and Hove has undertaken its own appraisal of all schemes currently funded by the Better Care Fund (BCF) to determine their continued effectiveness in delivering national priorities. In Brighton and Hove, it has been agreed to retain all existing schemes funded. Further schemes, specifically supporting hospital discharge have been added, using additional national funding made available for 2022/23.

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people, address health inequalities and achieve the best use of the collective resources in Brighton and Hove. By developing a joint Brighton and Hove Health and Care Place Plan and having a clear place-based focus, we continue to 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 the local population.

The BCF is a critical element of delivering the Brighton and Hove placed based plans as it provides significant joint funding to support schemes which deliver on our local priorities.

1.1 Our priorities for 2022/23

Building on what has been delivered so far, our plans set out the collective work being undertaken at Place and the shared priorities of:

- Services that meet the needs of the population
- Fucus on reducing health inequalities
- Models of responsive, high quality, co-ordinated and personalised care, supporting prevention, early intervention, and wellbeing
- 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 through recovery and restoration of health and social care services following the Covid-19 pandemic. The primary focus has been on increasing out of hospital support and capacity and supporting of discharge hub to ensure timely discharge and the most appropriate care being available when required.

Our 2022/23 plans include learning from the Covid-19 pandemic which have accelerated new ways of working, including greater co-ordination and joined up working to meet current challenges, across acute hospitals, social care, primary care, mental health and community-based services.

The system learnt from new models of delivery that resulted in a collaborative response and a flexible approach to deploying resources. We continue, as a system to use this learning to help reshape a stronger and sustainable future.

2. Governance

The Brighton & Hove Health and Wellbeing Board (HWB) retains responsibility for governance and oversight of the BCF and receives quarterly monitoring reports. Responsibility for ongoing oversight is delegated to the Health and Care Partnership (HCP) Executive Board which meets monthly. The core responsibilities of the BCF Steering Group in relation to the BCF are in the section 75 Agreement.

The BCF briefing paper was presented at the B&H ICP Executive Meeting on 17 August 2022, with representation from;

- Brighton and Hove City Council
- Brighton and Hove (NHS Sussex)
- Sussex Community Foundation Trust

- Sussex Partnership Foundation Trust
- University Hospitals Sussex NHS Trust
- Voluntary Sector in Brighton and Hove

The members of the meeting supported the actions outlined.

The BCF Plan will be presented at the Brighton and Hove Health and Wellbeing Board on 8 November 2022. Prior to final sign-off by the HWB Chair, the Brighton and Hove BCF Plan 2022/23 will go through the formal internal governance pathways of both Brighton & Hove City Council and NHS Brighton and Hove at Place.

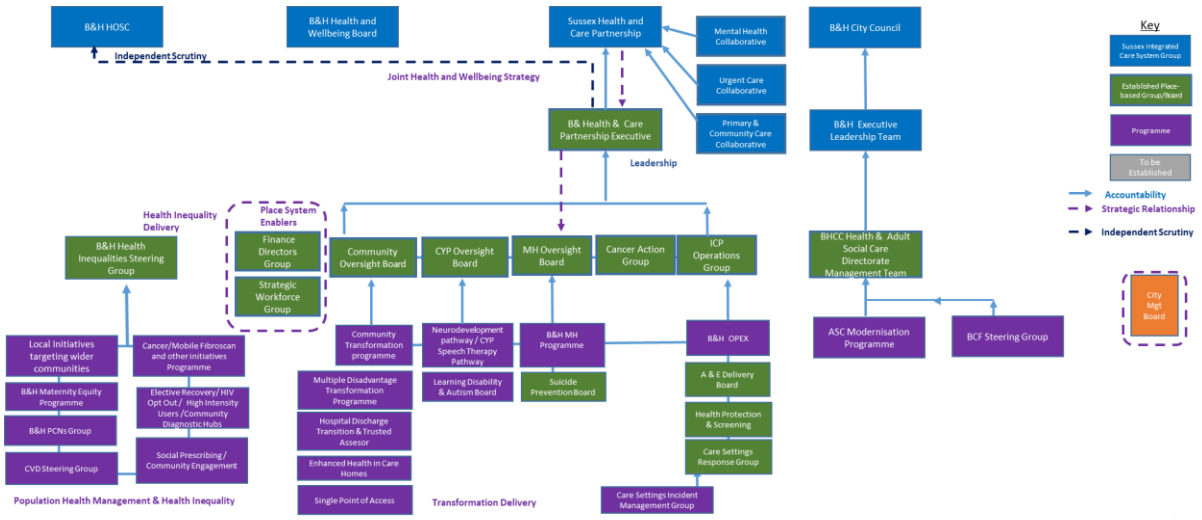
In addition to approval of the plan there is ongoing and regular stakeholder engagement. For example, with providers in respect of discharge planning and monitoring, system performance, and at individual scheme level with NHS providers, private sector providers, VCSE providers, and housing authorities.

The table lays out the approval timeline with local dates added for review by Better Care Fund Steering Group, HCP Exec Board (review by partners), ICB Commissioning Group, Chief Finance Officers and HWB *(N.B this will after submission and areas will need to inform of their HWB approval before plans can be approved).*

BCF planning requirements published	**19 July 2022**
NHS Brighton & Hove and BHCC Approval	
Better Care Fund Steering Group	30 August 2022
Brighton and Hove Operational Command Group (OCG)	9 September 2022
Brighton and Hove ICP Operational Group	12 September 2022
ICB Commissioning Group	12 September 2022
HCP Executive Board sign off (Delegated to NHS Place Executive Managing Director & Executive Director of Health & Adult Social Services)	26 September 2022
Final submission	**26 September 2022**
Brighton & Hove Health & Wellbeing Board	**11 November 2022**

The BCF plans support delivery of the Brighton and Hove transformation programmes focussed on urgent care and urgent community response. Schemes and services which fall within these areas are monitored via the relevant Oversight Boards. *See diagram 1 below for further clarification:*

Diagram 1: Brighton and Hove Place Partnership system governance structure



3. Overall BCF plan and approach to integration

As a health and care partnership, Brighton and Hove are committed to making the collective vision a reality. It is recognised this will required both cultural and behavioural shift across all system partners. But the system remains committed to working in partnership to find new and innovative ways of working with a greater emphasis on population health outcomes and reducing health inequalities.

The 2022-23 Place Based Plan sets out the ambitions for the Brighton and Hove population and provides a framework to develop plans that deliver agreed health and care priorities with the greatest positive impact. The plan sets out a concise vision, with clear outcome measures. It links together multiple health and care organisational plans and workstreams within Place and the Sussex ICB.

The Brighton and Hove HCP will also work alongside partners across Sussex as part of the Integrated Care Partnership/Sussex Assembly (ICP) and NHS Sussex Integrated Care Board (ICB). Where appropriate for supporting better health outcomes, a pan-Sussex approach will be adopted.

Significant progress has been made as a system. It is encouraging to see that through the dedication and commitment of staff the system is delivering above average levels of activity and are one of the top systems in the country in relation to recovery and restoration of services. Although, it is recognised there is more work to do, the system is in a strong position to take the next steps over the rest of 2022-23 in making the vision a reality.

3.1 Our joint priorities for 2022-23

Building on the local response to the NHS Long Term Plan and the local priorities set out in the Place Based plan, the key priorities supported by the BCF are to:

- Expand statutory and voluntary sector services directed at supporting hospital discharge. In particular, with the development of streamlined and aligned working outlined with the Brighton and Hove Hospital Transition Plan
- Build on the existing progress to enhance prevention, reduce health inequalities, the gap in life expectancy in the county. We will do this through co-ordinated 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 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
- Build on existing progress to take forward the recommendations from the JSNA for Multiple Compound Needs (including Homelessness), which will ensure that people with lived experience will be engaged by local organisations in a broad range of roles related to service design and delivery. Services will be underpinned by a care-coordinator approach that is inclusive of all levels of needs. The services will practice a trauma informed approach, addressing the wider determinants of health in a gender informed and culturally sensitive manner

Support key and targeted intervention to our identified the “Plus” Population groups (Carers, including young carers, mental Health transition in children and young people aged 16-25 years, globally displaced communities, - those seeking asylum, refugees, vulnerable migrants and; Lesbian, Gay, Bisexual, Transgender and Questioning+ communities) Our Place based 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 to deliver against our population health priorities, the NHS Long Term Plan and Brighton and Hove priority objectives. The alignment of organisational and strategic plans, with oversight of the Brighton and Hove Health and Wellbeing Board, supports the delivery of our place-based plans and programmes.
- A range of joint and integrated commissioning arrangements. This includes pooled budgets, along with shared arrangements for commissioning voluntary and community sector services. There is also joint work in understanding additional care capacity requirements, with an agreed approach to bedded care and lead commissioner arrangements
- Our shared Hospital Transformation Programmes aims to further align health and social care services to meet growing demand this will be done 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-centered care

As set out in the Place Based plan, the key aim shared across all organisations is to improve the health and wellbeing of local people and reduce health inequalities. This will be achieved through delivering more integrated and personalised care, and enhanced focus on prevention through early intervention and reablement after episodes of ill health. Considering the population health and care needs of the local population, the system has 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 needed
- Increase sustainability through increased integration between community and social care services alongside closer working with Primary Care, mental health and the voluntary sector
- Promote increased aligned working between the health and social care system to maximise the 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 partnership delivery plans outlined above that are critical to improving health and wellbeing and reducing health inequalities in Brighton & Hove; our strong priority to meet our population's health and care needs is more integrated care across all age groups.

In 2022/23 the Brighton and Hove system will:

- Build on a shared approach to the leadership and management of services across acute and community health and adult social care, to support the deployment of teams and resources to work together more effectively across services for the frail elderly and others with complex and long-term care needs.
- Ensure a focus on the links and broader engagement with primary care and the VCSE to support the multi-disciplinary team (MDT) working and care coordination developments in primary care, and the implementation of anticipatory care.
- Support the above, agree and implement our approach and model for planning and delivering services in a geographically sensitive way within the city, 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 BCF already funds many services across health, social care and the voluntary sector that support community care and specifically hospital discharge.

Strategic plans to increase the integration of services have been agreed by Brighton and Hove partners, in the form of a transformation programme, aimed at streamlining pathways and aligning existing services towards a single operating model.

The transformation programme is significantly wider than the Better Care Fund however the BCF plans for 2022-23 seek to support the key priorities outlined above. It will also find a programme Manager, who's role it will be to deliver the system's vision

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. Aging Well Problem
    b. Enhanced Health in Care Homes
    c. A range of services provided by the Voluntary and community sector including support for people with sensory impairment
    d. Delivery of Personalised Care via Social Prescribing Link Workers

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

c. a network of local community-based services working together to support good mental health and wellbeing in Brighton and Hove.

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. Carers Services
b. Health and Social Care Connect (Single point of Access)
c. Housing support and adaptations
d. Maintaining social care services
e. 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. Homelessness Primary Care Service
c. Discharge to Assess – additional bed-based capacity
d. Additional Domiciliary Care capacity
e. Hospital discharge support
f. 24/7 access to Health & Social care (Single point of Access)

These schemes support the delivery of all 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 2021/22 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. Implementing the BCF Policy Objectives (national condition four)

4.1 Supporting Discharge (National Condition Four)

Since March 2020 the overall focus of the health and social care system has been to support people during the Covid-19 pandemic. This has included specific support to discharge patients out of hospital, managing surge, releasing capacity, and ensuring appropriate care is provided.

The Covid-19 pandemic accelerated new ways of working to support hospital discharge in developing more integrated and joined up working across acute hospitals, social care, primary care, mental health, and community-based services. This has necessitated the development of a new delivery model, supporting greater collaboration, flexed resources, and the use of digital options to meet system pressures. It has also provided significant learning to reshape a stronger and sustainable future.

The discharge transformation programme as set out in section 4.3 seeks to build and consolidate the outcomes achieved through this integration and joint work.

We have been working in partnership across Sussex alongside patient groups for a number of years to develop strategic solutions that deliver the nationally mandated outcomes required of an Integrated Urgent Care (IUC) system and in 2022/23 we will continue to deliver this ambition. Our model for IUC covers four core components:

1) NHS111-Clinical Assessment Service (CAS) including NHS 111 First
2) Sussex Home Visiting Service
3) Urgent Treatment Centre's (UTCs) - co-located and stand-alone
4) Place-based models of Integrated Care

These four components work together alongside primary care, community pharmacy, ambulance and other community-based services, to provide locally accessible and convenient alternatives to A&E for patients who do not need to attend hospital. This also supports primary care and keeps people closer to home.

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

The system will continue to work with the Sussex Urgent Care Programme to support patient flow and reduce pressure on urgent care services. The Discharge transformation programme has commenced with the aims of supporting patient flow and reduce pressure on urgent care services through managing Medical Ready for Discharge (MRD) patients better. The system set itself an ambition to minimise the length of time a person is waiting for their supported discharge from hospital, with a focus on working collaboratively to improve system and processes to reduce delays.

Much of this work is supported by BCF funded schemes, either directly the creating community capacity, or investing in VCSE discharge to settle services, or indirectly by increasing social work assessment capacity.

4.3 D2A plans

Our plans for transforming discharge through the Discharge Transformation Programme (DTP)

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

It is a system objective to return people to their own homes via the Home First pathway, wherever possible. Brighton and Hove system partners have agreed to further develop existing discharge models, through a Hospital Transition programme aimed at further aligning and jointly locating health and social care teams, going beyond the principles of Discharge to Assess (D2A) and work towards a 'Discharge to Recover' approach. To facilitate this change the key workstreams of this work are:

- Trusted Assessment
- Home First
- Domiciliary Care and Care Home Framework Procurement
- Combined sourcing and placement team
- Developing the functionality of Discharge Hub
- Right sizing and Reablement Streaming

The BCF will also be used to commission additional key services to support a safe transfer of patients and encourage flow. This includes investment into capacity and a dedicated programme manager to push integration between partner organisations and to facilitate a culture change required to meet achieve the desired outcomes.

In addition, the Brighton and Hove system also supports safe and effective hospital discharge by:

- Maintain a small number of providers commissioned to assess and accept patients 7 days a week
- Patients and families are engaged and fully involved in the planning long term care needs asap within the discharge process with a choice protocol in-place and implemented throughout the system and is supported by the emerging discharge transition programme that embeds personalised care across the system.
- Extensive range of VCSE services available to support discharge process – home to settle and care services in place with agreed extended roles to include medication prompts and meal prep.

Other VCSE services include:

- Post-discharge checks for high-risk patients
- Social prescribing and signposting services available
- VCSE High Intensity Users service in place

A Care Home support service is in place to work with high referring homes or homes identified as having specific risks within the Enhanced Health in Care Homes programme to include;

- Enhanced primary and community care support
- MDT support including coordinated health and social care
- Falls prevention, reablement and rehabilitation
- Joined up commissioning of health and social care
- Workforce development
- Data, IT and Technology

For housing related services, a systemic response is in place supporting early needs assessment, integrated working. There are plans in place to establish clear links between housing and discharge teams, including equipment needs.

Aligned commissioning of discharge services:

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

- Optimum utilisation of all bedded capacity (Pathway 2) to stream patients into appropriate settings
- Build Home First/Crisis Response domiciliary model alongside reduction in Interim bedded capacity
- Agreed Organisation Development across health and social care to improve consistency of approach to discharge with an emphasis on promoting independence supports implementation of future model
- Robust communications plan to be developed to support health and social care staff and patients and their families/carers
- A focus on the wider issues of workforce
- Developing in symphony with key partner programmes, such as Community and Primary Care Transformation

4.4 High Impact Change Model - action plan

The Brighton and Hove High Impact Change Review is attached here.

BH - High Impact Change Review v2 (C

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

A large proportion of current BCF investments are directly supporting hospital discharge or admission avoidance:

- **IPCT-SCFT** - provides community nursing capacity within each Primary Care Network to provide a proactive service to patients in their own homes
- **District Nursing Support** – Out of hours domiciliary nursing and night-sitting supporting end-of-life patients and urgent patients
- **Hospital Discharge** – Directly funding D2A bedded capacity
- **Community Equipment** – provides community equipment and minor adaptations to people in their own homes or within care to support safer independent living. In many cases, the availability of this equipment facilitates hospital discharges
- **Home First/Urgent Homecare** – provides urgent additional homecare capacity to patients following rapid community assessment after hospital discharge
- **Lindridge Medical Cover** - provides medical cover supporting 25 community step-down beds
- **Crisis Service/Link Back** – voluntary sector providers, utilising social prescribing techniques to deliver support and low-level care to discharged patients (increasingly being used as an alternative to homecare). This is increasingly being used as an alternative to homecare provision on discharge
- **Carers Hub** - highly praised by service users, providing single point of access and support to carers, helping to avoid emergency admission

A review of all current BCF funded schemes in Brighton & Hove has indicated opportunities to consolidate some component parts to improve outputs but found there were no schemes that could be stopped or scaled back without incurring an adverse impact on the local system. All the current schemes have been retained, although further reviews will be undertaken to ensure the continued robustness of each.

System pressures remain within the Brighton and Hove system. In response in 2022/23 £1m derived from a combination of the uplift to the CCG's minimum contribution and a small contingency will be used to ensure discharge supported community bedded capacity is moved to being recurrently funded via the BCF (previously HDP funded schemes). This is aimed at stabilising community capacity to support hospital discharge.

4.6 Personalised Care

Personalised Care is a key enabler to reducing health inequality, giving people the same choice and control over their mental and physical health they have come to expect in every other aspect of their life.

Social Prescribing Link workers are key in connecting people to wide range of community services that can help improve health and well-being. The delivery of Personalised care is key to the role of a Social Prescribing Link Worker to deliver the 3 population approaches in the comprehensive model of Personalised Care; Shared decision making, Personalised care and support planning, enabling choice, including legal rights to choose.

Aligned to the requirements set out in the PCN Network Contract DES for Personalised care, our Social Prescribing service will deliver a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.

4.7 Social Prescribing

Social Prescribing improves outcomes for people by giving more choice and control over their lives and an improved sense of belonging when people get involved in community groups. It is also effective at targeting the causes of health inequalities and is an important facet of community and neighbourhood centred practice.

Together Co have been providing a **Social Prescribing** service in Brighton and Hove since 2014. This service, commissioned by NHS Sussex, is funded by the Better Care Fund. Social Prescribing is delivered in a number of different ways in order to provide targeted interventions;

- Working closely with the West Hove PCN and Brighton Deans and Central, the service provides specialist support to the **PCNs Social Prescribing Link Workers** through the provision of training, peer support and 1:1 supervision
- A **City Wide Social Prescribing service** which aims to reduce health inequality and improve outcomes for people who may not traditionally access services via their GP practice by;
- **A Social Prescribing Plus** service which aims to further tackle health inequalities in Brighton and Hove by providing complex case link workers to support LGBTQ and Black, Asian and minority ethnic (BAME) people, language and interpreting services and specialist Gypsy, Roma and Traveller link workers. This service is delivered in partnership with specialist social prescribing VCSE providers:
    - Friends, Families and Travellers – for the Gypsy, Roma and Traveller communities
    - LGBT Switchboard Trans Link – for trans and non-binary people
    - Trust for Developing Communities – for people from BAME backgrounds
    - Sussex Interpreting Services – for those with a language need

These services deliver metrics which support avoidable admissions. Local Quality Requirements to capture the impact of this service on health inequality are reporting on the impact of this service on areas of deprivation, ethnic communities, LGBTQ and people with one or more long term condition.

4.8 Population Health Management

The Brighton and Hove system is committed to delivering change through a whole-area approach with a clear focus on outcomes to improving population health and ensure partners sign up to common goals. The principles of Population Health Management (PHM) is fundamental to make this real and enables us to use data drawn from across partners to identify people with deteriorating health (including those who may be slipping through the net) to influence behaviours and lifestyles which lead to poor health.

PHM will enable PCNs to deliver true Personalised Care with their local partners. Together, the three Ps (PHM, PCNs, and Personalised Care) forms a core offer for local people which ensures care is tailored to their personal needs and delivered as close to home as possible.

The Brighton and Hove BCF schemes support the delivery of anticipatory care, providing services for those patients who are at high risk of unwarranted health outcomes, to live well and independently for longer, through structured proactive care. Schemes provide anticipatory care to the most disadvantaged in our population, informed by the population health needs, the Brighton and Hove JSNA; drug and alcohol support, Social Prescribing, services which support the elderly population, mental health (including Dementia), long term conditions, carers, homelessness and housing.

4.9 Integrated team plans

The Brighton and Hove BCF schemes provide integrated care and work across organisational boundaries including Primary Care Networks, Adult Social Care, community NHS services to maximise effectiveness and reduce duplication. Multidisciplinary teams are in place to support the needs of those with long term conditions to reduce hospital admission or to support people being able to return home quicker, with more access to practical care and non-medical support, including advice on housing, cleaning, benefits, and carers, links to other support groups/VCSE organisations.

Integration provides good patient outcomes in the provision of both immediate and longer-term care, including palliative or end of life care, following hospital discharge.

4.10 Disabled Facilities Grants (DFG) and Wider Services Objectives and Outcomes

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

The DFG promotes the prevention of ill health (falls), avoidable hospital admissions, improves hospital discharges, reduces residential / nursing home admissions and promotes quality of life and wellbeing through major and minor home adaptations.

For Brighton & Hove our services are aimed at achieving the following outcomes;

- Enable older & disabled people to make choices that reflect lifestyle and circumstances and being able to remain living safely at home for as long as possible
- Fund home adaptations preventing people from needing to move into a care homes
- Improve housing quality and support
- Increase effective support to vulnerable fuel poor households and those most at risk of the health impacts of cold homes
- Proactive and preventative support by helping people stay healthy and remain independent

In Brighton & Hove there are consistently <5% DFG applicants admitted to hospital during 2021/22 and we work based on an average of 168 assisted hospital discharges per annum

4.11 Supporting Unpaid Carers

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

The Brighton and Hove Carers Strategy – *THINK CARER! – Building a Carer Friendly City (2016-2020)* adopted the NHS England Commissioning for Carers definition of a family and friend unpaid carer:

"A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who couldn't manage to live independently or whose health or wellbeing would deteriorate without this help. This could be due to frailty, disability or serious health condition, mental ill health or substance misuse."

Carers Hub

Brighton and Hove Health and Adult Social Care Assessment Services, currently (date 8.8.22) have 2022 known carers within the system and have completed 784 carers assessments/reviews/joint assessment and have 910 carers receiving services.

The Carers Hub which is funded by BCF provides services which support unpaid carers, the locally commissioned single point of contact for carers within the City, have (as of 30.6.22) 3,892 carers that they have contact with, have completed 136 Carers Assessments between April-June 2022; they provide a range of services within the Hub, through a partnership of organisations, and has an excellent reputation within the City, as well as being a high performing contract.

There are 2 specific projects, within the Hub, whose referrals and activities are significantly increasing, without additional funding in place:

Changes Ahead (specialist carer support for carers of people with mental health needs) are commissioned to support 50 carers per year, and are actively supporting 73 in the first quarter –

carers of people with mental health needs are increasing significantly, and for many of these carers, the person they care for is not receiving statutory provision, and they are the sole support for some people with extremely complex needs.

Young Carers Project – this project has seen dramatic increase in referrals, and individuals they support – 2017 when the Carers Hub started the YCP supported 90 YC's; 2018 -2019 105 YC's; 2019 – 2020 120 YC's; 2020-2021 235 YC's; and in the first quarter of 2022 – 2023 82 YC's, with an estimate of over 300 YC's being supported this year.

The Brighton and Hove Carers Rapid Needs Assessment 2016 made 6 Recommendations which will form part of the work funded by the BCF in Brighton and Hove:

- Services and commissioners should consider how to target services at groups identified as being under-represented within services (e.g. males, working age carers).
- Ensure that organisations that work with young people and with young carers specifically are aware that young carers are at increased risk of a number of poor outcomes and can respond to these risks including linking them into appropriate services such as physical and mental health services.
- Ensure that impact of carers' services can be demonstrated by including the same questions in carer's reviews as the carer's assessment (for example, questions about the impact of caring on wellbeing and the risks to physical and mental health).
- Ensure that the data collected by Adult Social Care is complete and quality checked, to provide a robust source of evidence about carers and their needs.
- Ensure that Adult Social Care are collecting data on the protected characteristics for all carers accessing services, including religion and sexual orientation, as well as armed forces personnel.
- Review the list of groups of carers at higher risk/with higher needs and prioritise those that more information is needed about or more specialised work is needed on. Research could be carried out with these groups to find out why they don't access services

These recommendations fed directly into the Brighton and Hove Carers Strategy 2016-2020 – the strategy has 4 main themes regarding building on a carer friendly City – Carer Friendly Social Care; Carer Friendly Health; Carer Friendly Employment; and Carer Friendly Education.

5. **Equality and health inequalities**

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

Our diverse City of nearly 300,000 people is the 131st most deprived local authority in England (of 317) according to the 2019 Index of Multiple Deprivation (IMD). Some areas are more affected by deprivation than others and there are significant variations in health outcomes across the city.

Brighton and Hove is a city with a very diverse community and a younger population (83% aged under 60 compared with 76% national average) that has significant diversity in all manners i.e. sexuality - Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) 11.5%, BAME 19.5%, 131st most deprived nationally, carers 9%. There are over 3000 known refugees/globally displaced migrants in Brighton and Hove; fifth highest homelessness, over 4000 people with known multiple disadvantages (4,180 receiving any of substance misuse, homeless or offending services (2018). Of the 4,180 people with multiple disadvantages1,670 receive two or more of these services, 460 received all three services and 2,170 were also estimated to have mental health problems. The average age of death for those with multiple disadvantages was 43 years compared to the overall average of death of 77 years.

Sussex's Vision 2025 sets out how we will achieve better health and care for all, through better health outcomes, equity of access and sustainable health and care services. Its ambitions support the

national requirements of CORE20Plus5 in relation to reducing health inequalities related to deprivation, SMI and Learning Disabilities, reducing inequalities in maternal deaths and stillbirths, improving early diagnosis of cancer, improving hypertension case finding and treatment and early mortality from Chronic respiratory disease.

The Core20PLUS5 approach is a national programme and requires each System to identify its 20% most deprived areas, its Plus /inclusion population groups experiencing worst access, experience and outcomes and plans to address 5 Clinical priorities -Hypertension treatment to target, Chronic Respiratory Disease, Serious Mental Illness Physical Health Checks, Cancer Early Diagnosis and Maternity Continuity of Carer. This national programme is firmly embedded in the Sussex Improving Population Health Strategy, Sussex HI Strategic Framework and within Tackling Neighbourhood HI DES implementation plans.

All PCNs are supported in utilising data and insight largely focused on identifying and addressing the Core20PLUS5 priorities and populations; with provision to engage target populations and to co-design interventions to address unmet needs and reduce HI. We are developing a toolkit, including a HI Dashboard for the five key clinical areas. The dashboards will provide GP practice and PCN-level data segmented by age, gender, deprivation index and ethnicity. It will be further developed to support other priorities and will enable us to segment for health inclusion and protected characteristic groups.

A number of the Brighton and Hove BCF schemes support the national requirements of CORE20PLUS5 in relation to reducing health inequalities related to deprivation, Serious Mental Illness and Learning Disabilities, reducing inequalities in maternal deaths and stillbirths, improving early diagnosis of cancer, improving hypertension case finding and treatment and early mortality from Chronic respiratory disease.

The Social Prescribing service is contributing to the delivery of CORE20PLUS5 working closely with PCNs to target social prescribing specifically to carers and to support need for translation services for our displaced communities. Our Social Prescribing service is also working with our commissioned Community Connectors in areas of deprivation to reduce health inequality.

The “Plus” Population groups for Brighton and Hove are currently being defined and but data and insights have identified population need which is supported by the schemes funded by the BCF:

I. Carers, including young carers
II. Mental Health Transition in Children and Young People aged 16-25 years
III. Globally displaced communities, - those seeking asylum, refugees, vulnerable migrants and;
IV. LGBTQ+ communities as an additional group who also experience health inequalities and that should be acknowledged through Equalities Impact Assessments (EQIAs) and system wide action

5. Conclusion and Recommendations

The Brighton and Hove scheme review has been completed for all health and social care schemes with all key lines of enquiry set out for the Sussex wide review covered in that. A consolidated summary of the review will be considered locally by Brighton & Hove BCF Steering Group with recommendations to ICP Executive and to inform the HWB report in November to sign off 2022-23 plan.

Initial findings from the review are:

1. That there are opportunities to improve contractual control, reporting and KPIs for some services that are BCF funded
2. There are opportunities to consolidate some component parts to work better together for a greater synergy and improved output
3. There are no schemes that obviously lend themselves to be stopped or scaled back without incurring an adverse impact on the local system

4. The key investments and largest investments are committed – i.e., they are funding costs that if the BCF doesn't fund will need to funded by another source so no net gain to the system resources e.g. BHCC pay costs and CCG funding towards SCFT block.
5. There are also very significant considerations (public and Cllr adverse reactions, CCG reputational risk) if we were to reduce funding commitments to BCF schemes such as carers and support to specific community groups