Appendix 1

Brighton & Hove Better Care Fund Plan 2023/24 - 2024/25

Better Care Fund Narrative Plan
2023-2025
Brighton and Hove Health & Wellbeing Board

1.Background

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and well-being and live independently in their communities for as long as possible.

The BCF has been one of the government's national vehicles for driving health and social care integration since 2013. It required NHS commissioning organisations (NHS Sussex) and Local Government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets that are aimed at supporting health and social care integration, governed by an agreement under section 75 of the NHS Act (2006).

The BCF has provided a mechanism for joint health, and social care planning and commissioning, focusing on personalised, proactive, and integrated approaches to health and care that support people to remain healthy for longer. This includes remaining independent at home or to return to independence after an episode in hospital. It brings together ring-fenced budgets from NHS Sussex allocations, and funding paid directly to Local Government, including the Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF).

The continuation of national conditions and requirements of the BCF in recent years has provided opportunities for health and care partners to further build on plans to embed joint working and integrated care. This includes working collaboratively to bring together funding streams and maximise the impact on outcomes for local communities.

With the establishment of the Sussex Integrated Care Board and the development of the new Integrated Care Strategy and Shared Delivery Plan this has built on the strategic direction set by the Brighton & Hove Health & Wellbeing Strategy. At a Place-based level we have retained our five priority areas of:

- Children & Young People
- Mental Health
- Multiple long-term conditions
- Multiple compound needs
- Cancer

These five priority areas are an integral part of the Brighton and Hove new Place-based Shared Delivery Plan objectives with Multiple Compound Needs being selected as the Place-based community frontrunner programme to support the development of Integrated Community Teams, one of the Integrated Care Strategy long term improvement aims. The BCF continues to support several of our local health & wellbeing priorities.

Looking forward a major focus of the Integrated Care Strategy will be the development of Integrated Community Teams with the aim to transform the way we deliver health and care services across our local communities in Brighton Hove. The aim is to ensure that services are person centred and holistic in their nature and provide proactive health & care services with a greater focus on prevention. These services will be delivered by Integrated and multidisciplinary community teams working across primary care, secondary care, social care and the VCSE. A lot of this existing provision is supported by the BCF and over the next couple of years we expect that these services will be further developed as we deliver our integrated community teams transformation programme.

2.Stakeholder Involvement

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 this integration is managed through the Brighton and Hove (B&H) Health & Care Partnership Executive and Better Care Fund Steering Group. This brings together Brighton and Hove City Council, and the 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
- Sussex Partnership NHS Foundation Trust
- Community Works who represents the Voluntary, and Community and Social Enterprise (VCSE) organisations in Brighton and Hove

The purpose of the B&H Health and Care Partnership (HCP) is to support delivery of our locally agreed plans and programmes of transformation for the recovery, stabilisation and future sustainability of our health and care system. Our aim is to work together as a system to ensure a focus on prevention, respond to identified Health Inequalities, deliver high quality, effective care, improve health outcomes, and the operational models that enable this, for the population in B&H.

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

- Providing Place based leadership in the delivery of the Sussex Integrated Care Strategy and associated Shared Delivery Plan. This will cover physical and mental health services across acute, community and primary care settings, social care, and prevention.

- Supporting the ongoing development and implementation of a 5-year integrated local Brighton and Hove Plan which forms part of the Sussex-wide Integrated Care Strategy ***Improving Lives Together***.

- Supporting the delivery of initial agreed priority programmes of transformation in three core areas of urgent care, planned care and community services.

- Supporting the delivery of the Shared Delivery Plan priorities:
    - **Long term improvement priorities**- integrated community teams, growing & developing our workforce, digital & technology information.
    - **Immediate improvement priorities**- primary care, urgent & emergency care, planned care, discharge.
    - **Continuous improvement areas**- health inequalities (including homelessness), mental health, learning disability & autism, clinical leadership, making the best use of our finances.
    - **Supporting the delivery of the Health & Wellbeing strategy and Place-based Priorities**.

We work with our population in a range of ways to ensure that the way our priorities are delivered fits with what people have told us is important about their health and care.

3. 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 bi-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 21 June 2023, 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 18 July 2023. Prior to final sign-off by the HWB Chair, the Brighton and Hove BCF Plan 2023/25 will have gone through the formal internal governance pathways of both Brighton & Hove City Council and NHS Sussex.

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, and VCSE providers.

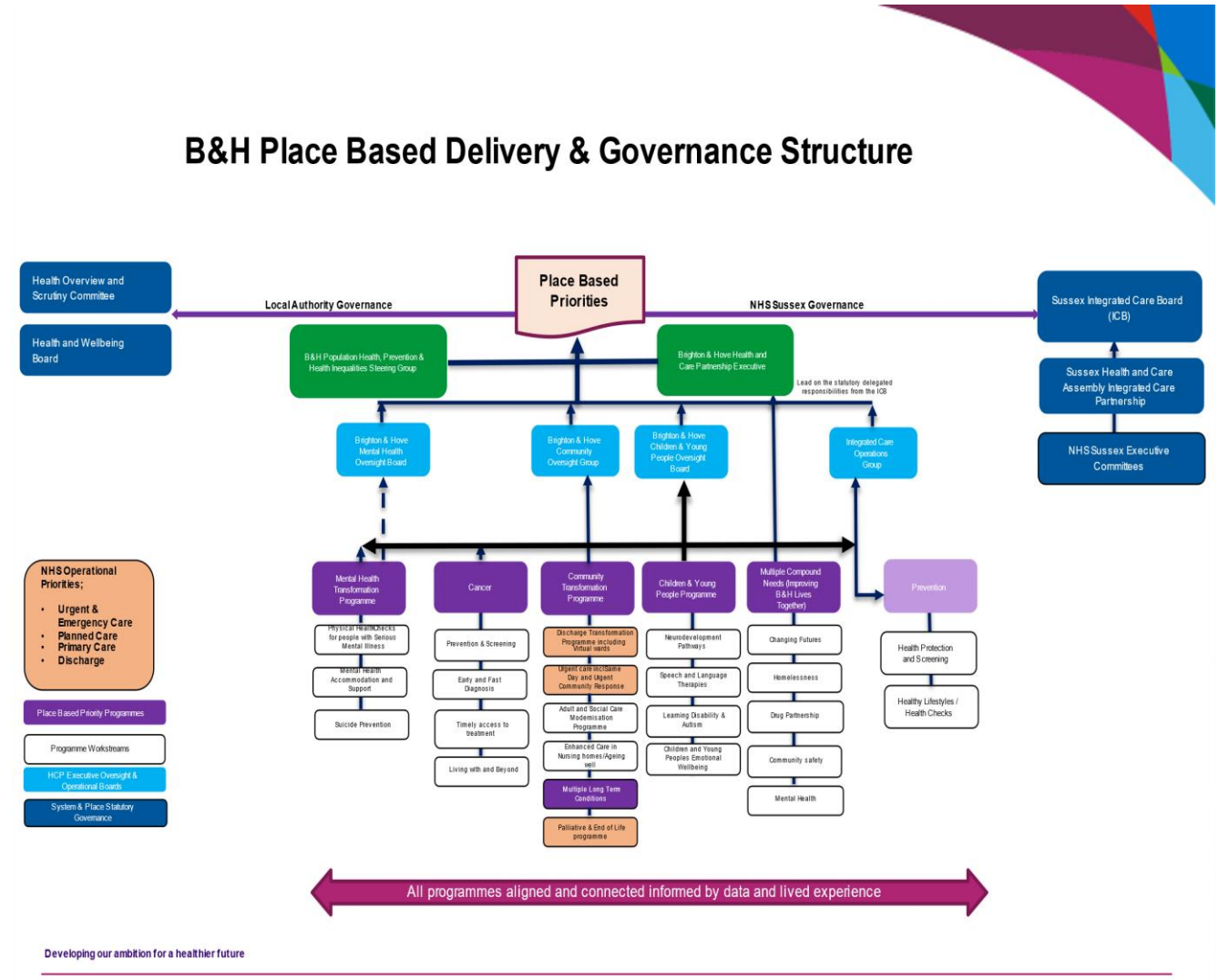
The table lays out the approval timeline with local dates added for review by Better Care Fund Steering Group, Health and Care Partnership (HCP) Executive Board (review by partners), ICB Commissioning Group, Chief Finance Officers and the HWB.

Final submission	**28 June 2023**
NHS Sussex Brighton & Hove and BHCC Approval	
HCP Executive Board sign off (Delegated to NHS Place Executive Managing Director & Executive Director of Health & Adult Social Services)	21 June 2023
NHS Sussex Commissioning Group	12 June 2023
Brighton and Hove ICP Operational Group	5 & 19 June 2023
Brighton and Hove Operational Command Group (OCG)	2 June 2023
Better Care Fund Steering Group	26 May & 23 June 2023
Brighton & Hove Health & Wellbeing Board	**18 July 2023**

The BCF plans support delivery of the Brighton and Hove transformation programmes focussed on urgent and emergency care schemes and services which fall within these areas are monitored via the relevant Oversight Boards.

The application of the Better Care Fund, including the Discharge Funds, supports the delivery of the Sussex Shared Delivery Plan, is captured through the Sussex and Place based structure oversight governance arrangements. Brighton and Hove governance arrangements link to the Shared Delivery Plan and System Oversight governance that encompasses health and social care, to ensure alignment of plans and benefits realisation through the current and future deployment of the BCF.

Diagram 1: Brighton and Hove governance structure



4.Executive summary

The vision of the Brighton and Hove Health and Wellbeing Board is to protect and improve health and wellbeing and reduce health inequalities, so that everyone can have a life that is as safe, healthy, happy, and fulfilling as possible.

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

Priorities for 2023-25

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

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

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

Key changes since previous BCF plan.

The Sussex-wide Integrated Care Strategy ***Improving Lives Together*** was launched late in 22/23 providing a strategic approach for ensuring the Better Care Fund across all parts of Sussex is focused on delivery of the key priority areas via a Shared Delivery Plan.

The BCF funded schemes are carried forward from the previous year with the following additions:

- Discharge Fund: LA Grant and ICB Allocation. The schemes funded by the Discharge Fund fall fully within the BCF plan following the initial roll-out in Q4 2022/23.
- For 2023/24, the ICB will fund additional hospital discharge schemes via the BCF.

5. National Condition 1: Overall BCF plan and approach to integration

Brighton and Hove is part of the wider Sussex Integrated Care System (ICS), created along with NHS Sussex in July 2022. It is a partnership of statutory (NHS and Local Authority) and non-statutory (voluntary sector) organisations. The agreed aim is to come together to plan and deliver joined up health and care and to improve the lives of people who live and work in the area.

The Brighton and Hove placed-based partnership is responsible for leading the detailed design and delivery of integrated services across the city and neighbourhood level. This partnership involves the NHS, Brighton Hove City Council (BHCC), community and voluntary organisations, residents, people who use services, carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

The purpose of bringing the stakeholders together is to:

- Improve outcomes population health and health care.
- Address health inequalities in outcomes, experience, and access
- Enhance productivity and value money.
- Help the NHS support for the social and economic development.

Together partners have agreed a Shared Delivery Plan for Brighton and Hove, integral to which are the BCF plans and funding priorities. The plan sets out a concise vision, with clear outcome measures. Central to this is having a clear understanding of health inequalities and population needs in developing plans at a neighbourhood level. The aim is to further integrate multiple health and care organisational plans designed to support the development of integrated community teams, a single point of access and local partnerships. All essential for improving health outcomes and reducing inequalities.

To further support integration, address health inequalities and enable people to stay independent for longer, statutory, and non-statutory partners are increasingly working to co- design services, which are better able to support local needs. Integral to this approach is the use of population health data to pinpoint areas of greatest need on which to focus.

The priorities outlined below in the Shared Delivery Plan, are aligned to and supported by BCF funding:

- **Multiple Compound Needs** (MCN), is the Place-based community frontrunner programme trialling a new integrated multidisciplinary team pilot, delivering a new integrated model of care for people with multiple compound needs. This will be supported by clear programme objectives, a compact agreement between system partners and an independent evaluation process.
- **Hospital Discharge**. Develop an integrated model and implement the 2023/24 hospital discharge transformation plan aimed at joining-up services, reducing hospital delays and deliver improvements aligned to the discharge frontrunner programme. This work also includes expansion of services supporting admission avoidance. Further expand statutory and voluntary sector services directed at supporting hospital flow and reducing emergency admissions.
- **Health Inequalities**. Build on existing progress to enhance prevention, reduce health inequalities, and the gap in life expectancy. This will be done 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. Working with Public Health to reduce the spread of blood-borne viruses.
- **Mental Health**. Implement the recommendations of the 2022 Brighton and Hove Mental Health and Well-Being JSNA, ensuring the expansion in the range of emotional well-being services in primary care; physical health checks for people with mental health issues, develop suicide and self-harm prevention action plan.
- **Children and Young People (CYP)**. Implement well-being action plan priorities that will include a new emotional well-being pathway for CYP and embed training at the point of induction for social workers.
- **Multiple Long-Term Conditions**. Development of cardiovascular disease reduction plan, including hypertension case finding and treatment, and the restoration of the NHS health check program with a health inequalities lens.
- **Cancer**. Build on existing priorities, working closely with public health, NHS providers and the VCSE to help detect cancer at an early stage through the uptake of screening programmes, including the expansion of targeted health checks, FIT testing and continuing my fibro scanning outreach service (responding to an area of known health inequalities).

Recognising the importance of integrated working, partners are increasingly working together to jointly commission services. Where there is a single commissioning lead, partners join procurement teams to ensure coordination across health and social care. This also includes pooled budgets, along with shared arrangements for commissioning voluntary and community sector services.

The Brighton and Hove place-based partnership 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 to support better health outcomes, a pan-Sussex approach will be adopted.

5.1 BCF Schemes Supporting Priorities

The Brighton and Hove BCF already supports schemes that promote the agreed priorities:

- Enhance prevention, personalisation and reduce health inequalities:
  - Aging Well Programme
  - Enhanced Health in Care Homes
  - A range of services provided by the Voluntary and community sector.
  - Supporting telehealth/Care Link services in people's own homes.
  - Delivery of Personalised Care via Social Prescribing Link Workers
- Support for people with mental health needs by ensuring access to a full range of services including:
  - Dementia services
  - a network of local community-based services working together to support good mental health and wellbeing in Brighton and Hove.

- 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.
  - Carers Services
  - Health and Social Care Connect (Single point of Access)
  - Housing support and adaptations
  - Maintaining social care services
  - Community Equipment services

- Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:
  - Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
  - Homelessness Primary Care Service
  - Discharge to Assess – bed-based capacity.
  - Domiciliary Care capacity
  - Hospital discharge support
  - Targeted Proactive Personalised Care for Urgent and emergency care high users.

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, local NHS Trusts, and the VCSE.

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 up in previous years 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.

5.2 BCF funded services support our approach to integration.

The Brighton and Hove BCF funds several services across health, social care and the voluntary sector that work together to deliver integrated services supporting community care and specifically hospital

discharge. This, along with the priorities laid out in the Brighton and Hove Shared Delivery Plan, form part of the system's response to the Fuller Stock-Take recommendations: streamlining access to care, increasing proactive and personalised care, and helping people stay at home for longer.

Strategic plans to support hospital discharge, led by a BCF funded programme manager, will further increase the integration of services as part of a systemwide transformation programme aimed at developing a single operating model. The programme is wider than the BCF, funding schemes within the plan support the key priorities.

One example of this is the Discharge Transformation Programme, which is a system wide approach aimed at to improving discharge and admission avoidance through increasing integration and coordination between NHS, Local Authority and VCSE providers. The main focuses are:

- Better streaming of patients through ward to discharge with identification earlier of the most appropriate pathway to meet their needs.
- Increasing functionality of the Transfer of Care Hub with an equal focus on community and acute discharges.
- Increasing home/domiciliary care capacity to support more people in their own home, with integrated health and social care pathway, agreed by all partners.
- Integrated health and social care front door services to increase redirection from Emergency Departments. Currently a high percentage of patients are elderly. It is anticipated between 4-6 redirections per day prior to admission into ED.

A major focus of the Integrated Care Strategy is the development of Integrated Community Teams with the aim to transform the way we deliver health and care services across local communities in Brighton & Hove. The aim is to ensure that our services are person centred and holistic in their nature and provide proactive health & care services with a greater focus on prevention. These services will be delivered by Integrated and multidisciplinary community teams working across primary care, secondary care, social care and the VCSE. It is anticipated that these teams will be set up on geographical basis across four localities in the city and on a city-wide basis where there are health population needs that are specific to communities of interest and identity.

The development of the Shared Delivery Plan objectives for integrated community teams is in its infancy. But a lot of the existing provision of community health and care services is aligned to and supported by the BCF, so over the next couple of years we expect that the BCF will be integral to how we further develop our local health and care services to meet the aims of the integrated community team's transformation programme.

5.3 Future Plans

In Brighton and Hove, the opportunity is being taken to enhance models for the way teams work together in communities and at neighbourhood level to help improve health outlines for different populations and remove barriers between organisations to enable them to do this.

- In May 2023 first all partner engagement event, in which ideas and proposals for neighbourhood development were discussed.
- Plan to establish a test and develop approach; looking to trial approaches in single neighbourhoods to be rolled out across the city if they are successful.
- Build on the existing related services and projects.
- Build on our original target operating model for community services to ensure primary care, mental health and services that impact on the wider determinants of health and wellbeing are fully a part of the model.

BCF plans in Brighton and Hove in 2023/24, remain largely unchanged at this point from those in 2022/23. All schemes have been reviewed by system partners and align to agreed national and local

priorities. The agreed plan is to continually review existing schemes to ensure they continue to be effective and/or continue to align to system priorities of addressing the health needs of the population in B&H and further developing integration of services.

6. National Condition 2: Supporting BCF objective 1: Enabling people to stay well, safe and independent at home for longer

The key aim of the Brighton and Hove Shared Delivery Plan is to deliver improvements the health and wellbeing of local people and reduce health inequalities. This will be achieved through delivering more integrated and personalised care, enhanced focus on prevention through early intervention and reablement after episodes of ill health. Integral to this is better understanding of the healthcare needs of different populations within Brighton and Hove and developing services better able to support these differing needs effectively.

Following the publication of local Joint Strategic Needs Assessment (JSNA) information broken down to neighbourhood level, Brighton and Hove is already in good position to understand the care needs of its local population. The Brighton and Hove system has committed to transforming to a new model of integrated care that will:

- Alongside statutory and voluntary partners and local communities develop multidisciplinary neighbourhood teams throughout the city, able to better understand and support the needs of different communities.
- All partners working together to address some of the wider determinants of health that are resulting in the current level of health inequalities.
- 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.
- Utilising more digital/telehealth options to help people remain safely for long with their own home.
- 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.

6.1 Carers Hub

Brighton and Hove Health and Adult Social Care Assessment Services, as of August 2022 had 2,022 known carers within the system and completed 784 carers new assessments / reviews / joint assessment, and with 45% (or 910 carers) needing support and receiving services. Proactively engaging and supporting carers will reduce the need for greater interventions for both carer and cared for – reduce hospital/primary care/social care provision.

The Carers Hub which is funded by the BCF provides services which support unpaid carers, the locally commissioned single point of contact for carers within the City. 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 two specific projects, within the Hub, whose referrals and activities are:

- **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.

- **Young Carers Project (YCP)** – referrals to this service have increased year on year since 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; 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 six Recommendations which form part of the work funded by the BCF in Brighton and Hove (the rest directly from the ICB):
    - 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 several 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.

6.2 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.

6.3 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 several different ways 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.
- **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 conditions.

7. National Condition 2 – Demand and Capacity Modelling

7.1 Our approach

Demand Assumptions:

- Underpinned by Trust Discharge Sitreps for 2022/23 for four core providers, providing analysis by Pathway.
- Growth 2022/23 to 2023/24: net neutral
- Phased by month by days in month with limited adjustments for seasonal variation.
- Pan Sussex assessment that 2% of Pathway 0 activity requires Social Support
- A limited amount of Pathway 3 activity transferred to Pathway 1 – Domiciliary care – in line with pan Sussex agreed focus on 'Home First' and evidence from East Sussex service leads.
- Analysis by 'sub pathway' (%) derived from review of patterns of referral 2021/22 and 2022/23; this analysis will be subject to further development as part of the Discharge Front Runner Programme

Capacity Assumptions

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 services (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy)
- Reviews with service managers were also undertaken to validate Pathway 1 services and available data sources.

Significant Demand and Capacity Gaps

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

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

8. National Condition 2 – Supporting Unplanned Admissions and Hospital Discharge

The Brighton and Hove system recognises the importance of patient experience and outcomes through measures that support hospital discharge and admission avoidance, especially in the elderly. It also acknowledges that integration and coordination between health and social care partners is the best way to achieve this.

8.1 Discharge Frontrunner Programme

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

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

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

As part of the Discharge Frontrunner programme the system has undertaken a comprehensive hospital discharge patient needs analysis, building on the work completed last year This identified several key challenges in delivering effective and timely discharge from hospital:

- Complicated pathways and the requirement for further integration between teams
- Challenges within the homecare market
- Short notice, non-recurrent nature of funding resulted in the purchase the right capacity in the system.

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

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

8.2 Brighton and Hove System

The BCF historically has funded several schemes directed at supporting hospital discharge and admission avoidance, including increasing intermediate and homecare capacity, and supporting rapid community/hospital assessment, and telehealth technology. In 2023 the Brighton and Hove system has also benefited from additional hospital discharge funding, which it is used to further increase capacity and who could providers on long-term contracts to safeguard continuity.

The BCF also funds a Programme Manager post to support the delivery of the system's Hospital Discharge Transformation Programme, which includes:

- Further development of a new delivery model
- Establishing collaboration and integration of services
- Reduction of duplicate assessments
- Use of digital options to meet system pressures and share information.

The discharge transformation programme as set out in section 8.2 seeks to build and consolidate the outcomes achieved through this integration and joint work.

The Brighton and Hove system has been working in partnership across Sussex alongside and alongside patient groups for some time to develop strategic solutions that deliver the nationally mandated outcomes required of an Integrated Urgent Care (IUC) system. The local model for IUC covers four core components:

- NHS111-Clinical Assessment Service (CAS) including NHS 111 First
- Sussex Home Visiting Service
- Urgent Treatment Centre's (UTCs) - co-located and stand-alone.
- 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.

8.3 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.

8.4 Discharge Transformation Programme (DTP)

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, 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.

8.5 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

8.6 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:

- **Integrated Primary Care Teams** - provides community nursing capacity within each locality 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.
- **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, funding from additional discharge fund and utilising a combination of the uplift to the NHS'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) and additional homecare capacity is created. This is aimed at stabilising community capacity to support hospital discharge.

9. National Condition 3: Provide the right care in the right place at the right time

The transformation programme, service redesign schemes and developments are significantly wider than those funded by the Better Care Fund however the BCF plans for 2023/25 seek to provide the right care in the right place at the right time through:

- Continually working towards integration between health and social care services and work with our Primary Care Networks to embed proactive care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.
    - Frailty services
    - Carers Services
    - Housing support and adaptations
    - Maintaining social care services
    - Community Equipment services

Improve support for people with urgent care needs including targeted support for vulnerable people – by way of admission avoidance and supporting hospital discharge pathways:

- Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
- Urgent Community Response services
- Hospital Intervention team based in the hospital
- Discharge to Assess - bed-based capacity.
- Domiciliary Care capacity
- Hospital discharge support provided by the Voluntary Community Sector In
- 24/7 Health and Social Care Connect (Single point of Access)

These BCF schemes support the delivery of the BCF metrics with many of these schemes being jointly commissioned and jointly provided by Adult Social Care and local NHS Trusts. The schemes support the development of integrated local service delivery and the move towards planning and designing services around local communities as a cornerstone of our vision for integrating care and support.

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

loping direct referral pathways from hospital discharge teams into housing adaptations teams to provide adaptations to enable safe and timely discharge.

tisation of hospital discharge referrals

10. National Condition 3 – Discharge Demand Modelling

10.1 Our Approach

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

Demand Assumptions

- Underpinned by Trust Discharge Sitreps for 22/23 for four core providers, providing analysis by Pathway.
- Growth 22/23 to 23/24: net neutral
- Phased by month by days in month with limited adjustments for seasonal variation.
- Pan Sussex assessment that 2% of P0 activity requires Social Support
- A limited amount of Pathway 3 activity transferred to Pathway 1 – Domiciliary care – in line with pan Sussex agreed focus on 'Home First' and evidence from Brighton and Hove service leads.
- Analysis by 'sub pathway' (%) derived from review of patterns of referral 21/22 and 22/23; this analysis will be subject to further development as part of the Discharge Front Runner Programme

Capacity Assumptions

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

- Routinely produced performance dashboards for Pathway 2 and Pathway 3 services (Pathway 3 care profiles feature length of stay in line with pan Sussex strategy)
- Reviews with service managers were also undertaken to validate Pathway 1 services and available data sources.

Whilst the modelling has provided an ideal number of intermediate care beds for the system, but it is recognised that not all patients being discharged on the right pathway and that some pathway utilisation may be driven by availability of capacity rather than demand, usually into bedded care, where they remain for longer than modelled. This means the system currently operates with more intermediate care beds than it requires according to modelling. The main drivers for this are:

- a lack of onward homecare capacity to support people in their own homes impacting on acute discharge, community bed discharge, and home first services
- complexity of patients for the commissioned beds; over 65 with mental health and other physical needs

The system has modelled the level of homecare capacity it requires, but due to market forces is unable to achieve this level of provision. BCF funded schemes are directed at incentivising the market to increase capacity.

The system development of home first model supported by integrated health and social care teams, is the approach being taken to increase homecare capacity, support greater numbers of people in their own homes and reduce reliance on intermediate care beds.

11. National Condition 3 - High Impact Change Model

The High Impact Change Model and the NHSE 100-day challenge requirement have been reviewed with agreement all requirements are broadly met or developing and work continues to improve discharge pathways.

The Brighton and Hove priority remains the further development of the home first pathway to ensure people can return home with the support they need as soon as they are medically ready and key actions to progress this include:

- Further embedding the Home First model and associated processes
- Development of Urgent Community Response Services
- Agree delivery trajectory alongside associated reduction in intermediate care/DTA beds (noting existing pressures in current P1 pathway).
- BCF funded Project Management resource with clear leadership support to deliver the project at the pace required.
- Ensure programme plans with clear timeframes in place and monitored.

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

12. National Condition 3 - iBCF

The BCF and iBCF already funds many services across health, adult social care and the voluntary sector that support community care and specifically hospital discharge.
The ASC Discharge grant has been pooled into the Brighton & Hove BCF to facilitate additional adult social care and community-based reablement capacity, to reduce hospital discharge delays. It has funded:

- Mental Health Step-down capacity
- Additional intermediate care beds
- Bariatric bedded provision
- Increased Homecare capacity
- Discharge facilitation roles

13. Supporting 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."

The Carers Hub is a partnership of carers services providing information, advice, assessment, support, and dedicated services – offering a single point of contact (SPOC) to enable unpaid carers to access a wide range of services to support them in their care giving role. Specifically:

- Awareness raising/Info/Advice/initial Carers Assessment (Carers Centre) – all carers encouraged to refer to the Carers Hub, Hub provides Primary Care Carers Worker to support GP Practices re: Carers Quality Markers, including training and dedicated support for Working Carers (Employers for Carers)
- Dedicated Services – EoL carers project; YC project, Peer Support, Carers Reablement Project, My Health Matters, Dementia Carers support, Carers Engagement, Changes Ahead
- Carers Assessment Service **-** conduit between Carers Hub and HASC duty system
- Carers Hub aligns to B&H **CORE20PLUS5** '**PLUS'** groups to support carers, specifically young carers.

The Carers Hub has **3 Tiers:**

- **Tier 1: SPOC** for Carers (info; advice; signposting; assessment of needs; and awareness raising across services of the needs of carers, including Primary Health Care; Acute Care; and support for Working Carers). This Tier aims to reach over 4,500 carers per year.
- **Tier 2:** 7 dedicated projects within the Carers Hub Partnership:
- Young Carers Project – information, advice, 1:1 support; group work; and schools support for 5–18-year-old carers (provided by the Carers Centre)
  Changes Ahead – information, advice, 1:1 support; peer support for carers of people with mental health needs (provided by the Carers Centre)
  Carers Peer Support – a range of monthly peer support meetings across the city (provided by the Carers Centre)
  Carers Reablement Project – matching volunteers and carers to achieve specific outcomes over an 8-week period (provided by the Carers Centre)
  End of Life Carers – information, advice, 1:1 support and peer support for carers of people at the end of their lives, or life limiting conditions (provided by the Carers Centre)
  Dementia Carers Support – information, advice, 1:1 support, and peer support groups for carers of people with dementia (provided by Alzheimer's Society)
  My Health Matters – homebased respite, providing replacement care to enable carers to attend health-based appointments (provided by Crossroads Care)

- **Tier 3:** of the Carers Hub are the Carers Assessment Workers within Health and Adult Social Care, who can support with Care Act compliant Carers Assessments, support planning, and Carers Personal Budgets.

14. Disabled Facilities Grant (DFG)

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.

The Housing Adaptations Service is an integrated team of Housing Occupational Therapists (OTs) and Technical Officers responsible for the specialist assessment for all major housing adaptations (over £1,000) and the administration of the Disabled Facilities Grant (DFG) available to low-income households in the private sector to fund major adaptations, repairs, and renewals.

For 2022/23 the budget for DFGs was £2.24m within this 400k was allocated to discretionary grants as detailed below with an additional budget of £0.4m for the extension to the Warm Safe Homes Grant.

The total fund and associated policies describe the assistance available for essential housing repairs, renewals and improvements targeted at reducing injury and accidents in the home, tackling fuel poverty and carbon reduction in housing, and reducing delayed transfers of care. Importantly the policy enables the local authority greater flexibility in how it uses the Disabled Facilities Grant (DFG)

capital funding to better meet local needs and deliver several wider strategic aims to keep people safe and well at home.

14.1 The Health and Wellbeing Strategy

This strategies ambition is that we want everyone in Brighton & Hove to have the best opportunity to live a healthy, happy and fulfilling life. This strategy focuses on improving health and wellbeing outcomes for the city and across the key life stages of residents: starting well, living well, ageing well and dying well.

The strategy is underpinned by eight principle, Partnership and Collaboration, Health is everyone's Business, Health and Work, Prevention and Empowerment, Reducing Health in equalities, the right care, in the right place at the right time, engagement and involvement and keeping people safe.

14.2 The Connected City, the Sustainable Community strategy for Brighton & Hove

The policy contributes to making Brighton & Hove an inclusive city with high quality, housing that promotes health and wellbeing. The policy contributes to delivery of Housing Strategy priorities:

Improving Housing Quality - work to improve housing conditions in private rented and owner-occupied homes through renewal advice, assistance, and enforcement, improving Home Energy Efficiency, improving thermal comfort, and reducing fuel poverty and CO2 emissions. Improving Housing Support – through investment in a range of housing interventions, helping people remain independent helps to mitigate pressures on the more intensive and costly services provided by Adult Social Care, Children's Services and Health

It also contributes to improving health, care, and well-being by improving the housing conditions which influence health. The policy contributes to the Better Care Plan vision to support people to stay healthy and well by promoting independence and enabling people to fulfil their potential. The policy demonstrates how we will work with the community & voluntary sector, so they play an active role in supporting people to stay well, through the partnership work with Possibility People, and places an emphasis on reablement to support people to maximise their independence.

14.3 Affordable Warmth Strategy

The policy contributes to delivering priorities to tackle fuel poverty and effectively targeting more vulnerable fuel poor households and those most at risk of the health impacts of cold homes. It helps to maximise resources and opportunities for tackling the causes fuel poverty.

14.4 Carbon Reduction in Housing

The policy contributes to meeting the Council's ambition for the city to be Carbon Neutral by 2030 by helping to deliver the 'Warmer Homes Scheme' for private housing. It incorporates an additional £400,000 of Warmer Homes funding to increase the maximum grant available to make homes warm and safe and to allow for the installation of air source heat pumps where appropriate and feasible, in addition to insulation measures.

14.5 Funding Distribution

The total discretionary funding as described above is split across the following areas.

Hospital Discharge Grants

The hospital discharge grant scheme is available to support any older person or disabled person discharged from hospital or intermediate care to return home. This extra help is available to help make sure that the home is safe and ready to return to. The maximum grant is set at £2,500.

The coordination of applications for assistance under the Hospital Discharge Grant has been well managed working in partnership with Possibility People. Outturn during 21/22 shows 187 referrals into the Link Back Early Response service, 128 delayed transfers of care avoided

thanks to Link Back Early Response service interventions. It is estimated 256 hospital bed days saved at an estimated cost saving of £102,400, based on a conservative estimate of two days saved per patient at £400 per overnight stay - days saved have potentially ranged from 1 – 14 in some cases.

Referral Routes

1. referral from the dedicated Early Response Worker within the Help After Hospital team supporting Brighton & Sussex University Hospital Trust (BSUHT) discharge teams, hospital rehabilitation/
2. care teams, Health and Social Care teams or the Patient Liaison Service (PALS)
3. excludes packages of care funded by NHS continuing healthcare and is for a Maximum of £2,500

The grant is not specified, so any work that supports the discharge from hospital to home is eligible including: minor works, such as clutter clearance/deep cleaning, urgent home repairs hazards removal heating systems repaired/emergency heating.

The hospital discharge grants are administered by a third sector provider and an extract of their 22/23 evaluation of the programme is included at Appendix 1

The Handypersons Grant: This grant can be applied for directly or via the following organisations: Social Care, allied health professionals and volunteer /charitable organisations. The grant allows for necessary minor remedial works, adaptations that reduce increase falls prevention. Targeted at older and disabled adults. The maximum grant is set at £2,500.

Dispensing with the means test:

This grant enables the service to provide minor adaptations up to a maximum of £5,000 with the minimum of intervention, intrusion, and delay. Any application that appears likely to be in excess of £5,000, would require a standard means test to be applied as part of the application process.

Warm Safe Homes Grant:

This grant is made available to provide significant remedial and property improvements such as cavity/wall and loft insulation, improved energy efficient heating solutions, energy efficient windows and doors. This grant also provides access to necessary adaptions to increase safety in the home. This grant is targeted at low-income homeowner's and, private tenants in fuel poverty. The grant seeks to provide the most energy efficient installations that reduce energy costs. The grant is limited to £20,000.

Relocation Grant:

This grant aid those people eligible for a DFG but where their current accommodation/ property isn't suitable to meet their needs currently and into the future and where adaptions are either unfeasible or unlikely to meet future needs with a five-year period. The grant is limited to £20,000 and subject to the means test.

Basic Adaptations Grant:

This grant enables non-Occupational Therapy professionals to organise and provide minor adaptions up to a limit of £5,000, such as intercoms & entry systems, external / internal rails. This avoids delays and allows speedier access to necessary adaptions without the need for a full Occupational Therapy Functional Assessment and subsequent professional recommendations.

Making Homes Dementia Friendly:

This enables access to help to make accommodation better suited and so safer to meet the needs of people with dementia or other deteriorating neurological conditions such as Huntington's Disease, Parkinson's Disease, MS. The grant is limited to £2,500.

DFG Fees grant:
This grant is available to eligible applicants to offset the costs of application and subsequent scheme costs – in relation to professional fees. This would include the provision of private Occupational Therapy assessment and or Structural Engineer assessment and reports. The grant is limited to £2,500.

Funding in Excess of the Maximum Mandatory Grant:
This grant enables the Local Authority to have discretion to increase the grant award beyond the current statutory level of £30,000. This provides essential access to deliver larger more complex schemes that enable people with higher levels of need to remain living in their homes, for as long and as safely as possible. The current discretionary level is limited to £20,000 and it is recommended in this report that this is uplifted to £30,000.

14.6 Additional information

The DFG Housing policy, approved by Housing Committee in September 2017 and updated in September 2018, offers a wide range of DFG funded discretionary grants as described above to eligible households in the private sector for housing adaptations, repairs, and renewals. It helps promote choice and independent living, enabling older and disabled households to live safe and well at home. It takes a prevention led approach, targeted at reducing accidents in the home, tackling fuel poverty, and reducing delayed transfers of care.

The policy is delivered by the Councils Housing Adaptations service with the Home Improvement Agency services (HIA), formerly provided by Mears HIA, having been successfully in-sourced 1 June 2021. The policy is closely aligned to Health and Social Care priorities and contributes to delivering our Fuel Poverty and Affordable Warmth Strategy and the Carbon Reduction in Housing action plan.

15. Equality and health inequalities

15.1 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 health and ensure partners sign up to common goals. The principles of Population Health Management (PHM) are 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.

15.2 Health Inequalities

Our diverse City of nearly 300,000 people is the 131st most deprived local authority in England (of 317) according to the Index of Multiple Deprivation (IMD). However, there is wide variations within the city, with average life expectancy up to 9 years shorter in the most deprived areas, compared with more affluent parts.

Brighton and Hove is a city with 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%, carers 9%. There are over 3000 known refugees/globally displaced migrants in Brighton and Hove.

Brighton & Hove has some of the highest rates of homelessness and drug related deaths in the Country (fifth highest rate for homelessness). Over 4000 people are known to have Multiple Compound Needs (MCN's (described as individuals receiving support for 2 or more of the following services: substance misuse, homeless or offending, 460 received all three services and 2,170 were also estimated to have mental health problems)). The average life expectancy of those with MCNs is 41 compared to the overall average of death of 77.

Multiple Compound Needs as one of the five Place based priorities and is working with the Sussex wide Changing Futures Programme to support system transformation. Key programme deliverables are:

- Establishing an MCN system partner steering group to oversee the transformation programme.
- Multi-disciplinary Team Pilot Project to support proof of concept and inform future integrated service design and commissioning. The pilot project went live in Dec 22 and is providing targeted support and care coordination to over 80 people with 4 or multiple complex needs in the city.
- High Intensity Users scheme directed at supporting people with complex needs who have multiple ED attendances.
- Integrated hospital discharge step down pilot service for homeless people in the city.
- Established a Homeless Healthcare Strategy Group, which is ensuring the specific health needs and health inequalities homeless people face in the City is considered and informed through strategic clinical lens and this informs service redesign. This group is led by the specialist homeless primary care practice, funded via the BCF, ARCH Healthcare and involves specialist secondary care providers.
- Specialist wound care and podiatry service for homeless people.

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.

Several Brighton and Hove BCF schemes support 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.

Social Prescribing services, funded via the BCF, contribute to the delivery of CORE20PLUS5 priorities, working closely with PCNs to target carers and translation services for our displaced communities. Social Prescribing services are also working with commissioned Community Connectors in areas of highest 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:

- 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.
- 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.