Brighton & Hove Better Care Fund Plan 2021/22

November 2021
Draft

Contents

Brighton and Hove Better Care Fund Plan 2021/22

1. Executive Summary

For 2021/22, given the focus on recovery and the lateness of the Better Care Fund (BCF) planning cycle, all schemes funded for the previous year are retained.

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of our collective resources in Brighton & Hove. By developing a joint Brighton & Hove Health and Care Place Plan and having a clear place-based focus, we will ensure that the priorities for service transformation and integration required to deliver a new service model for the 21st century are grounded in the needs of our local population.

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

1.1 Our priorities for 2021-22

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

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

1.2 Key changes since our previous BCF plan

Since our previous BCF plan our focus has increasingly been on the way we can further integrate our services to support people during the Covid-19 pandemic, including out of hospital support and discharge hubs to ensure timely discharge and appropriate care. The Covid-19 pandemic accelerated new ways of working in more integrated and joined up ways to meet the significant challenges to restoring services, not only in hospitals, but also in social care, primary care, mental health and community-based services. This enabled new models of delivery that required a collaborative response and a flexible approach to deploying our resources including our workforce to meet system wide pressures, and this has provided significant learning to help reshape a stronger and sustainable future.

2. Governance

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

The Better Care Fund Briefing paper was presented at the Brighton and Hove ICP Executive Meeting on 20th October 2021, with representation from;

- Brighton and Hove City Council
- Brighton and Hove CCG
- Sussex Partnership Foundation Trust
- University Hospitals Sussex NHS Trust

The members of the meeting were supportive of the actions outlined.

The Better Care Fund Plan will be presented at the Brighton & Hove Health and Wellbeing Board on 8th March 2022. Prior to final sign-off by the HWB Chair, the Brighton & Hove Better Care Fund Plan 2021-22 will go through the formal internal governance pathways of both Brighton & Hove City Council and Brighton and Hove Clinical Commissioning Group.

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

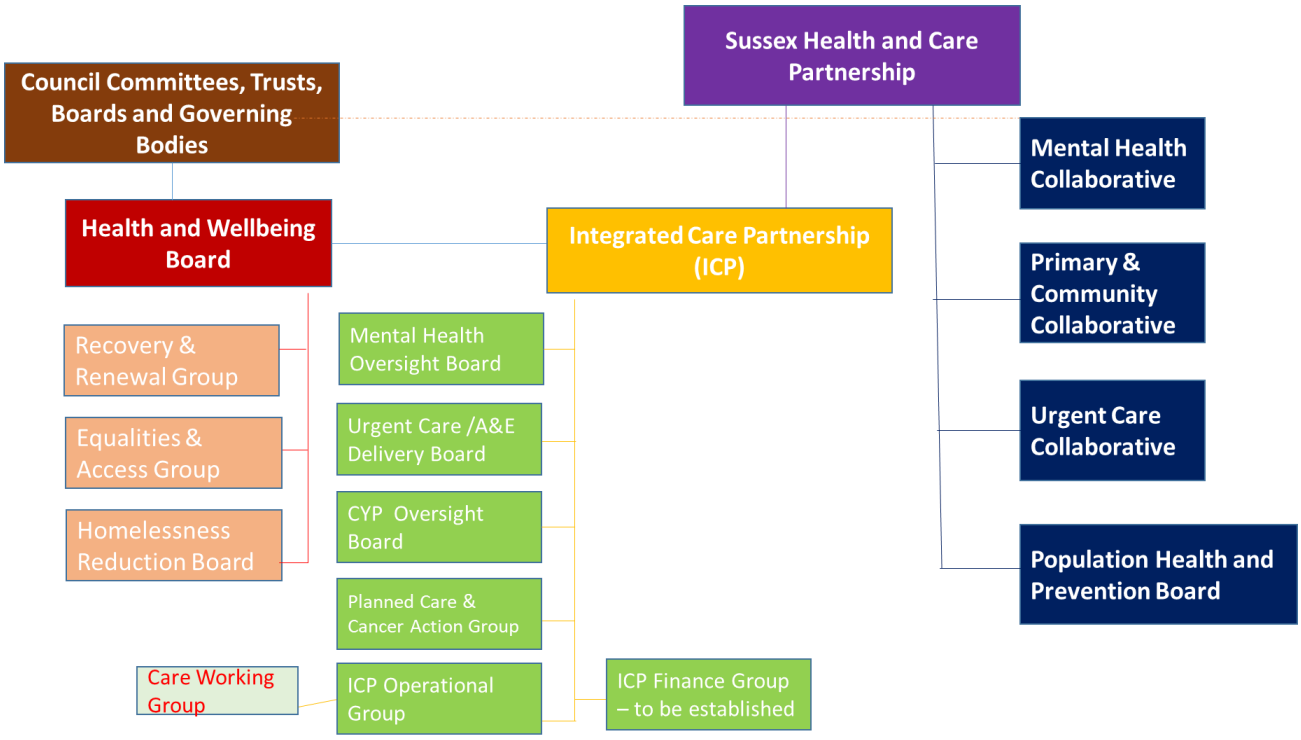
The table lays out the approval timeline with local dates added for review by Better Care Fund Steering Group, ICP Exec Board (review by partners), Chief Finance Officers and HWB *(N.B this will after submission and areas will need to inform of their HWB approval before plans can be approved).*

BCF planning requirements published	**29 September 2021**
Optional draft BCF planning submission submitted to NHSE	By 19 October 2021
Final submission	**16 November 2021**
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	16 November to 7 December 2021
Regionally moderated assurance outcomes sent to BCF team	7 December 2021
CCG and BHCC Approval	
ICP Executive Board sign off	17 November 2021
Better Care Fund Steering Group	TBC
Brighton & Hove Health & Wellbeing Board	**8 March 2022**
Cross-regional calibration	9 December 2021
Approval letters issued giving formal permission to spend (CCG minimum)	From 11 January 2022
All section 75 agreements to be signed and in place	31 January 2022

The BCF plans support delivery of the Brighton and Hove transformation programmes, most specifically urgent care and community. 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 Partnership system governance structure



3. Overall Approach to Integration

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

Our Place Based Plan sets out our ambitions for the Brighton and Hove population, providing the framework to develop joint health and care priorities year on year that will have the greatest impact on our population. The plan aims to set out a clear and concise vision, outcomes, priorities and measures for the ICP Executive Partnership, linking together the multiple health and care organisational plans and workstreams within Place and the Sussex ICS. We (the Brighton and Hove ICP) work with our partners across Sussex as part of the Sussex Health and Care Partnership (SHCP) taking collective action to improve the health of local people, ensure that health and care services are high-quality and to make the most efficient use of our resources.

We have made significant progress so far as a system and it is encouraging to see that through the dedication and commitment of staff we are 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 we recognise there is more work to do to get to where we want to be, we are in a very strong position to take the next steps over the rest of 2021-22 in making

our vision a reality.

3.1 Our joint priorities for 2021-22

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

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

Our 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 and planning arrangements to deliver against our population health priorities, NHS Long Term Plan requirements and Brighton and Hove priority objectives, and enable alignment of organisational plans across our whole system to support health and wellbeing, with a strategic relationship to the Brighton and Hove Health and Wellbeing Board for our system working and delivery of our agreed Brighton and Hove Health and Social Care Place Based Plan and programme.
- A range of joint and integrated commissioning arrangements. This includes pooled and aligned budgets and a shared approach to system finances, shared

arrangements for commissioning voluntary and community sector services, and significant joint work to understand additional care capacity requirements taking forward our agreed approach to bedded care both in and out of hospital through lead commissioner arrangements.

- Our shared integration delivery programme aimed at driving the changes needed to help manage growing demand on both NHS and social care services, by joining up care to support people to live as independently as possible and achieve the best possible health outcomes.

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

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

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

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

To continue to progress after delivering the pandemic response, in 2021/22 we 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 our resources and our teams to work together more effectively across services for the frail elderly and others with complex and long-term care needs.

- 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 Brighton & Hove Better Care Fund Plans support the delivery of the Brighton & Hove Health and Social care plans which address the local needs identified and the vision for integrating health and social care.

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

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

1. ***Enhance prevention, personalisation and reduce health inequalities***

    a. Falls and Fracture Programme
    b. A range of services provided by the Voluntary and community sector including support for people with sensory impairment.

2. ***Support for people with mental health needs by ensuring access to a full range of services including***

    a. Improved access to psychological therapies
    b. Dementia services

3. ***Continue to integrate health and social care services and work with our Primary Care Networks to embed proactive anticipatory care, and seamless wrap around care to people with long term care needs and conditions and those in care homes.***

    a. Frailty services
    b. Carers Services
    c. Health and Social Care Connect (Single point of Access)
    d. Housing support and adaptations
    e. Maintaining social care services
    f. Community Equipment services

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

a. Community based Intermediate Care and Reablement, by way of both domiciliary and bed-based care and support.
b. Discharge to Assess - additional bed-based capacity
c. Additional Domiciliary Care capacity
d. Hospital discharge support
e. 24/7 access to Health & Social care (Single point of Access)

5. *Improve services that deliver planned care for local people*

a. Diabetes self-management and pharmacy support
b. Medicines Optimisation in Care Homes
c. Dietician support to medicines management

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

In addition, focus has been given to developing preventative services which adopt a proactive approach to supporting people at earlier stages of care pathways.

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

4. Supporting Discharge (National Condition Four)

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, manage surge, release capacity and ensure appropriate care is provided. Some of the plans we have set out in previous years were paused with system governance adapted to help deliver the emergency response. The Covid-19 pandemic accelerated new ways of working in more integrated and joined up way to meet the significant challenges to restoring services, not only in hospitals, but also in social care, primary care, mental health and community-based services. This enabled new models of delivery that required a collaborative response, flexed resources including workforce and the use of digital options to meet system wide pressures and provided significant learning to reshape a stronger and sustainable future.

We have been working collaboratively across Sussex and with 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 2020/21 we have continued to deliver against 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.

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

We will continue to work with the Sussex Urgent Care Programme to support patient flow and reduce pressure on urgent care services. We commenced the Systems Discharge Improvement programme to support patient flow and reducing pressure on urgent care services through managing Medical Ready for Discharge (MRD) patients better. We set ourselves an ambition to minimise the length of time a person is waiting for their supported discharge from hospital once they are medically ready to leave. The ambition is to reduce the time that patients spend waiting to be discharged, with a focus on working collaboratively to improve system and processes to reduce delays.

4.2 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** – spot purchase of community bedded capacity
- **Community Equipment** – provides community equipment and minor adaptations to people in their own homes or within care to support safer independent living
- **Home First/Urgent Homecare** – provides urgent additional homecare and reablement capacity to patients after 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)
- **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.

Despite significant investment in schemes supporting hospital discharge, system pressures have remained. In response, £400k of the uplift to the CCG's minimum contribution has

been used to support investment in transferring Home Care providers to block / commissioned hours contracts. This is aimed at stabilising and increasing homecare capacity to support hospital discharge.

5. Disabled Facilities Grants (DFG) and Wider Services Objectives and Outcomes

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

6. Equality and Health Inequalities.

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.

Whilst the health inequalities that our population experience are not new, Covid-19 has significantly exacerbated inequality and impacted population, communities and individuals' physical and mental health. Failure to address this will lead to greater inequality, therefore, addressing health inequalities is critical and central to our work as a Sussex Health and Care Partnership and 'at place' within the ICP.

In response to our population needs and associated health inequalities we are developing our roadmap for integration which incorporates a refreshed focus on how we approach health and wellbeing and health inequalities in our work, this includes the following:

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

We have committed to transforming the way we work at Place to promote wider integrated working in our communities between the health and social care system and the full range of services that impact on the broader determinants of health and reduce health inequalities, including housing, employment, welfare, transport, environment and leisure and voluntary, community and social enterprise sector (VCSE) services and support.

The key shared priorities for addressing health inequalities & our areas of focus for 21/22 will include;

- Primary care developments and Primary Care Network delivery, for example supporting the growth of Population Health Management capability, anticipatory care, multi-disciplinary team working and care coordination. This will include engagement of personalised care roles within PCNs - social prescribing link workers, health and wellbeing coaches, and care coordinators - to ensure that personalised, quality, care approaches are taken forward.
- Further developing the Brighton and Hove social prescribing model.
- Continue to invest in services providing direct health and care support to the homeless population
- Develop and agree a shared outcomes framework and integrated delivery model for Adults with Multiple and Complex Needs
- We have committed to reframe local priorities to incorporate impact of Covid19, lessons learnt including from the Covid vaccine roll out and introduce a transformational approach that will reach all members of the community e.g., Homeless, Learning Disability, LGBTQ and the BAME communities.
- Take forward our ambition of creating an Integrated Homeless Hub with holistic, flexible, integrated and co-located, multi-disciplinary model for the population
- Delivered a consolidated Out of Hospital Community Healthcare Bedded Model for Brighton and Hove patients to provide resilience
- Partners will work together to develop a robust communication and engagement approach that is appropriate and culturally sensitive and competent; using updated modern tools co-developed with communities (to support improved access, experience and outcomes).
- As part of our commissioning framework, we will ensure that overarching goals to address health inequalities are embedded; for example, preventing people from dying prematurely, enhancing quality of life for people with long-term conditions and helping people recover from episodes of ill health or following injury.

7. 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 21/22 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

8. Further references

Brighton and Hove Health and Care Partnership Plan 2021/22

Appendix 1 - Brighton Place Based