BCF Context and Governance Review

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. The BCF encourages integration by requiring ICBs (previously CCGs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

The Better Care Fund in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups (LJCGs) provide a joint commissioning framework for the delivery and implementation of the BCF Plan enabling locally relevant placed-based decisions. There are Terms of Reference for the LJCG that are updated on a regular basis to ensure strategic overview with ensure robust budget management.

A system-wide review of how the BCF operates across Surrey is in progress and due to be reported on towards the end of 2022/23. Initial engagement with Surrey partners as part of this review suggests there is broad consensus that the current approach to allocation for the scheme is working well to allow for local innovation and to develop solutions tailored to local need. Going forward, there are potential changes that could be made to support local initiatives:

- Setting system-wide expectations and ambitions relating to outcomes
- Providing support to evidence impact and outcomes of schemes.
- Providing formal mechanisms to support sharing of good practice and reporting impacts and outcomes.

It is recognised within the review, that linking the BCF to prevention spend mapping has the potential to encourage a new way of allocating resources, using a robust evidence base to target resources and to drive prevention far more than it has to date. Whilst maintaining opportunities for local innovation, there is the opportunity for Surrey BCF to lead the way on redistributing resources to drive prevention, aligned to the Public Health grant and its key role in the prevention agenda.

This work is being taken forward by an integrated team of Surrey Heartlands and Frimley Health and Care ICS' colleagues and Council individuals and will be shared with partners towards the end of the year.

Health and Wellbeing Board:

Surrey

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

Surrey County Council, Local Joint Commissioning Groups made up of reps from Surrey County Council, ICS, District and Borough Councils as follows:

Surrey Heath

Surrey Downs

North West Surrey

East Surrey

North East Hants and Farnham

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East Berkshire

Guildford and Waverley

How have you gone about involving these stakeholders?

Local Partnerships are the key element to ensuring involvement and on-going stakeholder engagement. District and borough council representatives regularly attend local joint commissioning group meetings and are actively leading on communities and prevention work. East Surrey, in particular, has established the East Surrey Prevention and Communities Board, which has facilitated strong, effective place-based partnerships including engagement with local residents, VCS, and other local service providers. Surrey Downs ran an innovation fund at the end of 2021-2022 to support local groups.

In addition, as part of a separate Surrey-wide review, a series of meetings was held with individual LJCG chairs to gain insight to their operations.

Executive Summary

Surrey's two strategic priorities for the Better Care Fund align with the national priorities, which are:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

Surrey BCF is working towards these priorities by:

- mapping spending against prevention strategies, in order to maximise value and efficiency

- maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs
- integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care
- enabling people to return home sooner from hospital - excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home

Alongside ongoing investment in existing BCF Schemes, examples of BCF Surrey-wide and local place-based funded activity which support these strategic priorities for 2022-2023 include:

- Across Surrey £650k Discharge to Assess schemes
- Further local area-based investment in:
  - Autism Friendly Communities - providing support to communities in Surrey to be inclusive of people with Autism
  - Falls Prevention Packs supporting people to stay well at home
  - GP based in A&E to help reduce avoidable admissions
  - Safe and Settled service – supporting discharge from Hospital where low-level support is required
  - Community Discharge Nurse – planning discharge to community settings
  - In East Surrey, the Growing Health Together programme will aim to engage local communities with over 15 social and health projects and additional GP support jointly funded by each PCN. Each PCN will be working on different initiatives that reflect the needs and priorities of their individual communities
  - Community capacity to support referrals from social prescribers and health and wellbeing coaches in Surrey Heath
  - New roles supporting hospital discharge and flow in Guildford and Waverley
  - Commitment to support homelessness case worker in Surrey Heath
  - Tech to Connect, training to residents to enable social inclusion through the use of technology

In Surrey, as nationally, the effects of Covid-19 are still being felt, not only in exposing health inequalities, but the labour shortage in Health and Social Care. Surrey, again as nationally, is also gearing up to help residents through a 'cost of living crisis', the effects of which will be felt particularly harshly this winter. Surrey's Health and Wellbeing Strategy previous refresh included a strengthened focus on health inequalities. This continues to be reflected in work developing across system partners to better target and reduce health inequalities. Surrey's Better Care Fund Plan for 2022-2023 contains a number of schemes that focus on addressing health inequalities and, through regular review, we will continue to develop its support for the ambitions and priorities of the Health and Wellbeing Board.

The BCF operation throughout Surrey is also under strategic review as a whole. Previous schemes have been allowed to continue and be given time to 'bed in', particularly after the disruption of COVID and as a result of many years of short-term planning, so that KPIs can be effectively measured. A decision to continue 'as is', while this review is carried out thoroughly is shown in the continuation of schemes already commissioned. It is acknowledged that there are areas where strategy and targeting should be updated and these will be identified through the review. Additionally, a new management structure for the BCF is being embedded to support and implement the review and its findings. It is expected that the process of implementation will begin Q3 22/23.

Governance

The Better Care Fund in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups (LJCGs) provide a joint commissioning framework for the delivery and implementation of the BCF Plan enabling locally relevant placed-based decisions. There are Terms of Reference for the LJCG that are updated on a regular basis to ensure strategic overview with ensure robust budget management.

Each LJCG meets and oversees the delivery of Surrey-wide initiatives such as the Handyperson Scheme, Community Equipment and Carers services to ensure that they are tailored appropriately for their Place and uses the BCF to fund a programme of local initiatives. The remit of LJCGs includes overseeing the performance of these initiatives, with representatives invited to present progress, outputs and outcomes and future plans. In Surrey Downs, for example, representatives from D&B Councils attend every other meeting (six each year) to provide essential local knowledge.

The Surrey-wide Strategic Health and Care Commissioning Collaborative maintains oversight of the quarterly reporting submissions and Better Care Fund plans to NHS England and can request deep dives into BCF performance as required, particularly with regard to countywide commissioned schemes.

The Surrey Commissioning Committee-in-Common (which includes necessary delegated authority) oversees the development of the Surrey-wide integrated commissioning governance between Surrey County Council and the Clinical Commissioning Group Governing Bodies meaning this also has the local Better Care Fund within its scope.

Additional audits are undertaken through SCC's Internal Audit Team with recommendations complementing the above. Previous audits have looked at governance, performance reporting and monitoring arrangements.

As set out within planning requirements, Surrey's Health and Wellbeing Board signs off the final plan as it aligns to, and is an important contributor for, achieving the priorities within the Health and Wellbeing Strategy. This is a ten-year strategy first published in 2019 and was the result of extensive collaboration between the NHS, Surrey County Council, District and Borough Councils and wider partners, including the Voluntary and Community Sector and the Police. This engagement has been used for and continues to be considered in the shaping of local BCF programmes.

Similarly, the development of area and care group specific strategies informs and is shaped by Place based strategy.

The Health and Wellbeing Strategy now sets out how different partners across Surrey work together with local communities to commission services to achieve these aims, focused around two key priorities:

- Priority one: Enable people to stay well, safe and independent at home for longer
- Priority two: Provide the right care in the right place at the right time

To support this renewed focus, a strong link is also forming locally with the growing 'Empowered and Thriving Communities' agenda. This is due to the aspiration agreed in the refreshed strategy for the Health and Wellbeing Board to enable more community-led interventions to reduce health inequalities. BCF governance and forums will be essential in taking forward this renewed focus and the work to narrow the gap in health outcomes within the county.

Overall BCF plan and approach to integration

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Approach to Integration

The Surrey healthcare system recognises it will only deliver its health ambitions for the population of Surrey by working in partnership and integrating services. The system architecture in place following the Health and Care Act supports this, with the Integrated Care Partnership as the key space for Partnership working within the ICS.

The role of the Surrey Heartlands ICP in delivering system ambitions is:

- Coordinating a system approach to support delivery
- Maintaining a system focus on health inequalities (priority groups incl core 20+5)
- Alignment with system strategic objectives via Health and Wellbeing Board & Surrey Forum

The role of the Frimley Health and Care ICP is:

- Consider and set the strategic intent of the partnership; act as final approver of the ICS Strategy, including the proposed programmes of work, outcomes and intended benefits;
- Act as an objective "guardian" of the ICS vision and values, putting the population's needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus;
- Provide a forum for the consideration of Wider Determinants of Health and Health Inequalities, taking fullest advantage of the opportunities arising to hear the views and perspectives of the broadest range of local stakeholders and democratic representatives.

Surrey's ambition to create a truly integrated system has been operationalised within Surrey Heartlands by the creation of joint roles which span both the County Council and ICS. There are two Executive Directors: The Joint Executive Director for Public Services Reform and the Joint Executive Director of Adult Social Care & Integrated Commissioning who have been appointed jointly across both Surrey County Council and Surrey Heartlands ICS. Their remit as Executive Directors is to lead their services across the two organisations and support the population of Surrey to receive services which are integrated and operating in partnership. In addition to these structural changes, within the Public Services Reform Directorate there is the Health Integration Team which is led by another joint appointment between Surrey County Council and Surrey Heartlands ICS.

Within the Frimley Health and Care ICS, integration is happening structurally through jointly commissioned convenor posts in Learning Disabilities, Mental Health and Children's services as well as the Place based lead for Surrey Heath having a whole system relationship co-ordination role. In addition to this, Frimley Health and Care ICS has two Director roles who work across NHS and Local Government, supporting and enabling integration:

- Locality Director of Health and Social Care, Surrey Heath Adult Social Care, Surrey County Council and NHS Frimley.
- Director of Operations (NHS Frimley and Surrey Heath Borough Council)

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Many services commissioned through BCF are made up of multi-agency staff working together from health, social care and VCS organisations to deliver a joined up, person-centred pathway of care in line with the Critical five, which are as follows:

Keeping people well – doing more to promote prevention and stepping in earlier to prevent people's health deteriorating; and, when people do deteriorate, making sure they understand how and where to get the urgent help they need.

Safe and effective discharge – helping patients, their carers and families understand and safely navigate the options available to them from a much more joined up and improved community care environment

High-risk care management – making sure those who are most vulnerable receive the care they need in a coordinated and planned way

Effective hospital management – making best use of hospital resources to support patients safely and efficiently from the point of admission to discharge; this is also about delivering high quality care based on the 'Get it Right First Time' principles (a national programme designed to improve patient treatment and care through in-depth reviews of services and analysis of data/evidence)

Surrey-wide efficiencies – system-wide programmes that ensure we are working in the most efficient way - whilst maintaining high quality care - across areas such as diagnostics, clinical networks, more efficient use of our workforce, digital innovation, corporate and clinical support services, financial management and how we use our estates and facilities

Overall Plan

Surrey's Better Care Fund continues to drive organisations to work across boundaries to deliver outcomes for Surrey residents. All Surrey BCF partners are fully engaged with delivering joint objectives across all service delivery systems and within all partner contract management processes. A strategic approach to service delivery is promoted via Local joint Commissioning Groups and reflected within local plans, including local and regional Health and Wellbeing Boards. Individual BCF service contracts ensure patient choice is at the heart of service delivery and contract reviews ensure KPIs reflect patient engagement with services.

In Surrey we have an established structure which partners in community health, social care, voluntary organisations and primary care. These approaches and schemes are based on the principles of: people receiving person-centred care based on their needs; users only telling their story once and care coordinated around the person. Teams such as our Integrated Discharge Team and Homefirst Team continue to work together to deliver services to keep people out of hospital and to return them home with all the appropriate support they require as quickly as possibly following an acute admission with the aim of avoiding further admissions.

Examples of successful Joint Commissioning and Integration in Surrey:

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- Integrated Intermediate Care between the NHS community services and Local Authority Reablement service as a component of community-based care models, with additional partnership with VCS services to further meet the needs of service users.
- Implementing effective Information and Advice Service to help residents to navigate the health and care system.
- Creating multi-agency boards in place, in line with shared priorities, so that partners can join up to tackle the wider determinants of health (for example Housing Associations are members on East Surrey's Prevention and Communities Board).
- Primary Care Mental Health services are strengthening local clinical networks between GPs, social care professionals and Mental Health professionals.
- Providers are working together across the system to develop person-centred workforce plans and relevant training, supported by appropriate technology in care and multi-agency roles.
- Risk stratification tools are in place to identify residents at high risk of emergency admission to allow preventative interventions.
- Countywide commissioned carers services are being supported by years of established (and award-winning) joint commissioning, a committed Surrey-wide multi-partnership group, Surrey-wide providers and the desire for a consistent approach across the geography
- Frailty programmes are being successfully linked to other admission avoidance schemes, including falls prevention work through regular MDTs that bring together all areas of health, social care and other statutory services.

The ambition is to enable residents to be as independent as possible for as long as possible and so avoid or delay dependence on Statutory services. We are supporting people to be in their own homes, providing reablement/rehabilitation and short-term services to maximise independence – this will support the delivery of the reablement measure and help to reduce the number of new residential and nursing home admissions.

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. The population of Surrey was estimated to be 1.19 million people in mid-2018, projected to rise to 1.3 million people by 2039, with the largest rise anticipated in people aged over 65 years. An increased and ageing population inevitably results in an increase in the number of people living with complex needs such as long-term conditions, dementia, falls, depression and loneliness. For example, the number of people with dementia in Surrey is predicted to rise to 21,075 by 2025. Therefore many of the schemes currently in place will work to support Surrey's aging population. The services being commissioned are not fundamentally different in 22/23 compared to 21/22 due to the strategic review which is underway(see above). Previous schemes have been allowed to continue and be given time to 'bed in', particularly after the disruption of COVID and as a result of many years of short-term planning, so that KPIs can be effectively measured. It is expected that the effects of the review and a new management structure for BCF will begin to be seen from Q1 2023/24.

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Implementing the BCF Policy Objectives

Supporting people home from hospital is a key feature of Surrey's BCF plan and has been a feature of integrated working in Surrey since before the introduction of the Better Care Fund. Surrey is committed to continuous improvement in managing transfers of care and has built local plans to address areas for development.

We have been strengthening our approach to supporting patients to be discharged from hospital successfully and to achieve good outcomes with many different initiatives in Surrey. Across the county, prevention and self-management is taking place using a strengths-based approach which recognises the assets of the individual. We continue to place emphasis on personalised care across the system. This is being complemented by our strong personal budget offer in Surrey.

Within this year's BCF there are a number of programmes and schemes in place and being implemented with the aim of reducing delays and supporting timely discharge, without increasing admissions:

- Investment into Health and Wellbeing packs & a Falls prevention programme all help to support our local population to live healthier, independent lives and remain at home for longer. This is additionally supported via investment into the Reconnections pilot which helps reduce social isolation.
- The BCF funded Anticipatory Care Community Matron roles drive the delivery of the Anticipatory care LCS, playing a central role in the development of PCN-wide MDTs, ensuring co-ordinated anticipatory care in the community for complex patients, helping them to better manage their own conditions and

reduce avoidable hospital admissions. The matrons take a holistic approach to patient care, working closely with colleagues across health & social care and the voluntary sector.

- The implementation & subsequent expansion of the Phyllis Tuckwell Integrated Community Model has ensured that the team is now able to provide more families with high quality palliative and end of life care, increasing accessibility to all its services. Making timely interventions, tailored to the personal needs and wishes of patients, their families, and carers.
- Timely and safe discharge of patients following an episode of inpatient hospital care is supported via the BCF in multiple ways. There is funding for patient transport via the HOPPA Bus, additional reablement and therapy provision. Significant investment into our community nursing teams and in particular into In-Reach community nursing roles within the acute hospital have helped to ensure that more patients, and in particular those already known to our community teams, can be discharged quickly and safely to their usual place of residence.
- Organisations commissioned using the BCF to address the support needs of Carers in Surrey undertook a specific piece of work to look at Carers' experiences of discharge. This had led to action plans in each of the six acute trusts to improve Carers' experience and thereby facilitate successful discharge planning.

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BCF funding actively supports individuals across all discharge pathways through increased investment in the British Red Cross Independent Living Service - take home and settle service, which works in partnership with the handypersons service to help patients remain safe at home, preventing admission and supporting post discharge. The British Red Cross take home and settle services is available for pathway 1 and pathway 0 hospital patients. Volunteers contact all discharged patients 3 days post discharge and assist to link patients to local services and support networks including Wellbeing prescription services to signpost and/or refer people to community social and health services. This programme has been extended over the last 2 years to provide an additional 20% capacity providing support for over 100 individuals per month.

- BCF funded Community Equipment Services also enable timely and effective discharge to home and enables people to remain in their homes for longer, supporting independence.
- BCF funded schemes also support Occupational Therapy provision within acute and community settings to facilitate effective discharge.
- Integrated multi-disciplinary teams support early discharge planning and wraparound out of hospital
- Enhanced Reablement programmes to pool capacity and reduce delays. For example, the colocation of Reablement and Rapid Response colleagues in East Surrey is firmly established

- Discharge to Assess and Recover pilot – BCF has agreed to support a new rapid response discharge scheme to support pathway 1. The aim is to grow and develop an integrated health and care workforce that provides short term and intensive support to recover post-hospital discharge. schemes,
- Virtual wards are being established utilising technology-enabled monitoring at home with a dedicated clinical team providing an MDT approach to ensure each patient continues to receive the appropriate clinical and social care. This will allow patients to return home sooner, thus reducing the demand on hospital beds whilst encouraging independence and supporting patients' mental wellbeing.

With recent high demand on acute and domiciliary services, recruitment pressures and an anticipated energy cost crisis, the system is expecting to experience significant pressures over the winter period. Planning to support this demand and complex discharges is underway. The BCF has dedicated investment in the Discharge to Assess and Recover, Community Health Providers delivering the Virtual Ward models and additional bed capacity. This investment aims to enable assessments to be undertaken outside of an acute hospital bed to increase patient flow through the hospital and support reduction in unnecessary Length of Stay.

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Supporting Unpaid Carers

A ringfenced budget has been created within the BCF specifically to address the support needs of Carers, implementing the Surrey-wide Strategy for Carers 2022-2025.

The BCF Carers Budget makes provision for a range of externally commissioned services that are Surrey wide but are required to be appropriately tailored to local need:

- Carers Hubs: these are located in Surrey's 'Places' to increase visibility and encourage carers to access preventative support and early intervention
- Carer Breaks: through the provision of care for the cared-for individual
- End of Life Care and Carer Breaks
- Supporting Carers in Hospital Settings
- Carers Personal Health Budgets
- Carers Emergency Planning and Carer Passports
- Moving and Handling
- Young Carers
- Independent Giving Carers a Voice
- There is currently a review of the particular support needed by carers of someone using mental health services, expected to report by end September 2022.

There is also an innovation fund to address issues that arise and that are not otherwise addressed in the specifications for the commissioning services which may be Place-based.

The budget also enables the establishment, and during 2021-2022 the development of, the long-standing Integrated Carers team. This comprises SCC and ICB employed staff and is hosted within Surrey County Council within the new Surrey Heartlands ICB and works in partnership with North Hants and Farnham ICB.

The Carers Partnership Board has been refreshed and there are representatives of each of the newly established Place-based Carers Action Groups, which report into the Surrey Heartlands Carers Partnership board. These will interface directly with the LJCGs. The initial priority of East Surrey's Carers Steering group is to develop an action plan in response to the needs of carers in East Surrey.

Additionally, resources placed into expanding our Community Nursing & Hospice teams via BCF funding help to provide support in the community to our population and help reduce the burden placed upon unpaid carers.

Disabled Facilities Grant (DFG) and Wider Services

The DFG is paid to Borough and District Councils as set out in the grant conditions. Local Joint Commissioning Groups work at place to determine how best to spend this grant in their areas. This can be through specific forums bringing together Health and Social Care colleagues with Housing colleagues (East Surrey) or with OT's being involved in ensuring provision is reasonable and appropriate (Guildford and Waverley). Boroughs and Districts across Surrey work to ensure consistency and best use of resources. It is recognised that a DFG will need to be used to meet strategic housing needs in the future, this is where specific forums that are being set up can have the most impact.

As described earlier, the remit of LJCGs includes overseeing the performance of these initiatives, with representatives invited to present progress, outputs and outcomes and future plans. In Surrey Downs, for example, representatives from D&B Councils attend every other meeting (six each year) to provide essential local knowledge.

In addition, ICPs will be a delivery forum for issues which require a co-ordinated approach – in attendance will be D&B, health, VCSE, enabling health, social care and housing/environmental issues to be addressed and strategy set in one place. Further, the integrated commissioning function allows all these aspects to be considered by an integrated team.

Equality and Health Inequalities

BCF continues to address inequalities through its strategic alignment to Surrey Heartlands Critical Five, with the additional contribution of the Core20PLUS5 and Fuller Stocktake further localising health and care around communities and priority populations. This provides opportunities to assess demographics and wider determinants of health that impact on social and health inequalities allowing more accurate assessments of need to take place at a community level. The evolving structure of the health and care partnership alongside the continued incorporation of population health data through Graphnet assists LJCGs and BCF partners to target populations with the most appropriate services to achieve equity in access to health

and social care. In doing so, promoting independence at home, reducing admissions to hospital, and reducing the reliance on social care.

Surrey Downs LJCG set aside underspend from 21-22 to fund innovative services focusing on reducing health inequalities.

BCF funding continues to be allocated to projects/services directly addressing health inequalities:

- Tech 2 Community Connect, Growing Health Together and Wellbeing Prescription Service.
- Tech2 Connect provide free access to digital services for isolated individuals by providing free equipment, data and digital literacy support in the form of Tech Angels.
- Growing Health Together focuses on developing the health creation agenda in local communities across East Surrey. Growing Health Together Programme has picked up considerable momentum across all five Primary Care Networks with dedicated GP leads and committed engagement from local organisations, businesses, residents, schools, and places of worship. As a result, many projects have already been successful in reducing social isolation, improving mental health through multi-generational activities, increasing physical activity, facilitating green social prescribing, overcoming cultural barriers to health education, promoting heathy eating and many other outcomes, all of which are recognised to have a positive effect on individuals' health.
- The well-established East Surrey Wellbeing Prescription Service are working closely with PCNs, social care and community networks to understand inequalities and seek to address and reduce them. Wellbeing advisors utilise population health and primary care data to proactively identify priority cohorts within their local population and work with these groups to seek and develop services that meet their personal needs. By taking a targeted approach and assessing individual cases, the Wellbeing Prescription Service is able to efficiently navigate the system and tailor the offer to meet the demand.

These services strive to development stronger local communities to support local residents to lead more active, socially engaged lives. Addressing the wider, non-medical needs of individuals with the provision of asset-based community programmes - Growing Health Together, and personal development services such as Wellbeing Prescription enabling individuals to valuable parts of their community networks thus creating a sense of resilience.

Partners within the LJCG work closely with local groups and organisations representing seldom heard groups to ensure services are available, appropriate and co-produced to provide the right intervention at the right time.

East Surrey BCF will be using population health management pooled data (via Graphnet and resident's engagement) to assist with the identification, and

development of suitable provision of services to address health inequalities with identified population groups.

Surrey Downs supported a variety of organisations, key priorities being to encourage connectivity and reduce isolation (particularly following Covid), development of skills among young people; bereavement support (given the greater demand as a result of covid-related deaths).

It is also recognised that more can be done, particularly with regards to the use of data to target priorities and act. This is part of the review currently being carried out and we expect to see changes take place from Q1 23/24 onwards.

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