Surrey Better Care Fund (BCF) Plan 2023-25

Narrative Template

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SECTION 1: BCF Plan Development & Governance

Bodies involved strategically and operationally 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 representatives from Surrey County Council, integrated care systems (ICSs), district and borough councils as follows:
    - Surrey Heath
    - Surrey Downs
    - North West Surrey
    - East Surrey
    - North East Hants and Farnham
    - East Berkshire
    - Guildford and Waverley
- Surrey Strategic Health and Care Commissioning Collaborative
- Surrey Health and Wellbeing (HWB) Board, which includes representatives from: the Surrey voluntary, community, social enterprise sector (VCSE); and social care providers.
- Surrey Heartlands ICS executive team

How have you gone about involving these stakeholders?

Local Partnerships are the key element to ensuring involvement and on-going stakeholder engagement in the development of Surrey's Better Care Fund (BCF) approach. District and borough council representatives regularly attend Local Joint Commissioning Group meetings throughout the year and are actively engaged 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, the voluntary and community sector, and other social care providers and additional local service providers.

In March 2023 we held a BCF strategy workshop for HWB Board members, where Local Joint Commissioning Groups presented their proposed approach for 2023-25 which followed on from previous BCF programme review work carried out during 2022/23 This enabled feedback from a broad range of stakeholders, including NHS, public health, social care, local councillors and user representatives. We plan to repeat this workshop in autumn 2023 in order for system and local leaders to collectively review progress against key outcomes.

In May 2023, the Surrey Strategic Health and Care Commissioning Collaborative acted on behalf of the HWB Board and Integrated Care Partnership (ICP) to oversee preparation of the BCF plan. This forum brings together strategic commissioners and decision makers from Surrey County Council, Surrey Heartlands ICS and Frimley ICS to identify the opportunities for integration and collaboration and agree how best to implement them to ensure consistency of approach. It also provides a system

leadership role ensuring, on behalf of the HWB board, that BCF funding is used to best effect to deliver on key strategic priorities.

The draft BCF plan was then refined in response to feedback, agreed by Integrated Care Boards (ICBs) and Surrey CC's CEO, and signed off by Surrey's HWBB in line with national policy guidance. Finally, through integrated commissioning arrangements and the provision of Discharge to Assess in particular, many strategic groups and meetings established during this period are now able to contribute to the development of BCF funded services and initiatives that align with strategic and Place-based requirements.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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The BCF in Surrey has local commissioning arrangements. Seven Local Joint Commissioning Groups 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 Local Joint Commissioning Groups that are updated on a regular basis to ensure strategic overview is maintained across the whole system and that robust budget management is in place.

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Each Local Joint Commissioning Group funds a programme of local initiatives. The remit of Local Joint Commissioning Groups includes overseeing the performance of these initiatives, with commissioning leads and/or representatives invited to present progress, outcomes and future plans. Representatives from district and borough councils regularly attend Local Joint Commissioning Groups which helps provide essential local knowledge. The Local Joint Commissioning Groups also oversee the delivery of Surrey-wide initiatives such as the Handyperson Scheme, Community Equipment, Community Connections and Carers' services to ensure that they are tailored appropriately for their Place.

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

The Surrey-wide Commissioning Committees in Common (which includes necessary delegated authority) oversees the development of the Surrey-wide integrated commissioning governance between Surrey County Council, Surrey Heartlands ICS and Frimley ICS.

Additional audits are undertaken through Surrey County Council's internal audit team with recommendations complementing the above. Previous audits have looked at governance, performance reporting and monitoring arrangements.

Surrey's HWB Board signs off the final BCF Plan and ensures it is aligned with Surrey's HWB Strategy. This is a ten-year strategy (first published in 2019 and refreshed in 2022) 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. The Health and Wellbeing Strategy now sets out the need for different partners across Surrey work to together with local communities to commission services.

Please note that Surrey's governance arrangements are currently under review and BCF governance arrangements may adapt during 2023-25 in response to any broader changes in Surrey's overall governance structures. In 2023, Surrey invested in a dedicated BCF Programme and Policy lead whose role is to co-ordinate the overall approach and ensure transparency across the system. This post has been instrumental in the work being undertaken to streamline the governance arrangements and ensure decisions are made at the appropriate level.

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SECTION 2: Executive Summary

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. This will inevitably result in an increase in the number of people living with complex needs such as long-term conditions, dementia, falls, depression and loneliness. The Surrey system continues to experience increasing pressure on mental health services with the nationally predicted plateauing in demand expected to occur in 2023/24 yet to materialise in Surrey. Many of the schemes for 2023-25 will therefore be prioritised towards supporting Surrey's aging population. Whilst delivering against the national conditions, we will also be shifting the focus more toward prevention and earlier intervention, to ensure HWB Board priorities around tackling health inequalities are delivered.

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Surrey's Better Care Fund (BCF) continues to drive organisations to work across boundaries to deliver outcomes for Surrey residents. With the introduction of joint executive roles and the establishment of a partnership agreement between Surrey Heartlands and Surrey County Council for integrated commissioning, a key focus for 2023-25 is to build on the learning from the 2022/23 BCF review work, prevention spend mapping, and the recent BCF strategy workshop with partners in March 2023. This can be translated into a strategic programme of work that identifies opportunities to commission to system wide strategic priorities in a consistent and cost-effective way that supports the tailoring of delivery at Place, town and neighbourhood level, making sure we deliver against Surrey Community Vision 2030 ambition that 'No-one is Left Behind'.

A key priority is transforming Surrey's reablement offer to support all people, from the community and following hospital discharge and to have a stronger focus on prevention. Our future approach to reablement services is being developed and the recommissioning of a transformed collaborative reablement offer will take place later in 2023 that ensures a greater emphasis on working with community referrals as well as continuing to support discharge.

We will continue to strengthen our approach to supporting patients to be discharged from hospital successfully. We will also be seeking to: establish a longer-term Discharge to Assess offer; segment our market provision to flex capacity and meet fluctuating demand to support hospital pressures whilst also focusing on prevention; and ensure pathways for individuals to return or remain at home are clear and robust. In Surrey, approximately 40% of patients needing discharge are self-funders and we will be working with the national team to understand how NHS England and the Department of Health and Social Care can support systems to improve the flow of patients who are self-funders.

2023-25 will see the introduction of a new HWB Strategy Index for Surrey to enable a broader focus across health, wellbeing and the wider determinants of health and the Priority Populations of identity and geography. This will improve our understanding of outcomes that have many contributing factors. Our capacity and demand approach is still under development in Surrey, and we intend to progress

towards a more comprehensive approach to capacity and demand planning at Place level during 2023-25.

Surrey has an ambitious programme of work to deliver its strategic ambition to ensure No-One is Left Behind. This is supported by the ICS strategies for both Surrey Heartlands and Frimley Health and Care. We know that none of this can be delivered without system and partnership working and the BCF is a core component of how this can happen and brings together partners across Surrey to focus on the key priorities for our residents.

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SECTION 3: National Condition 1: Overall BCF Plan and Approach to Integrating Health, Social Care and Housing

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

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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 for 2023-25 will be prioritised towards supporting Surrey's aging population. The Surrey system continues to experience increasing pressure on mental health services with the nationally predicted plateauing in demand expected to occur in 2023/24 yet to materialise in Surrey. Shifting the focus more toward prevention and earlier intervention, building on prevention spend mapping work undertaken in 2022/23, will remain a key focus for the BCF programme in 2023/24 and 2024/25 to ensure HWB Strategy priorities around reducing health inequalities are delivered.

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 Integrated Care Partnership in both Surrey Heartlands and Frimley Health and Care have developed and delivered their strategies for the ICS:

- Surrey Heartlands: Our strategy - ICS (surreyheartlands.org)
- Frimley Health and Care: Our Strategy | Frimley Health and Care

These strategies detail the ambitions and vision each system has in delivering joined up health and care which put people and communities at the centre. The strategies were developed in partnership and demonstrate how organisations and services must be integrated in order to achieve our strategic ambitions.

The role of the Surrey Heartlands Integrated Care Partnership in delivering system ambitions is to:

- Coordinate a system approach to support delivery.

- Maintain a system focus on health inequalities (priority groups including the NHS Core20PLUS5).
- Align with system strategic objectives via the HWB Board & Surrey Forum.

The role of the Frimley Health and Care Integrated Care Partnership is to:

- 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.

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The ambition of Surrey's Community Vision in supporting its people is that No-One is Left Behind and:

- Children and young people are safe and feel safe and confident.
- Everyone benefits from education, skills and employment opportunities that help them succeed in life.
- Everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing.

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- Everyone gets the health and social care support and information they need at the right time and place.
- Communities are welcoming and supportive, especially of those most in need, and people feel able to contribute to community life.
- We want our county's economy to be strong, vibrant and successful and Surrey to be a great place to live, work and learn. A place that capitalises on its location and natural assets, and where communities feel supported, and people are able to support each other.

Surrey's ambition to create a truly integrated system has been operationalised within Surrey Heartlands by the creation of joint roles which span both Surrey County Council and the 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 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 have director roles that work across NHS and local government, supporting and enabling integration:

- Director of Integration NHS Frimley.
- Director of Operations (NHS Frimley and Surrey Heath Borough Council).

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.

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Overall Plan

Surrey's BCF 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 Group and reflected within local plans, including local and regional HWB 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 Home First 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:

- 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 multi-disciplinary teams that bring together all areas of health, social care and other statutory services.

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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.

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With the introduction of joint executive roles and the establishment of a partnership agreement between Surrey Heartlands and Surrey County Council for integrated commissioning the focus for 2023-25 is to build on the learning from the 2022/23 BCF review work, prevention spend mapping, and the recent BCF strategy workshop with partners in March 2023, and to translate this into a strategic programme of work that identifies opportunities to commission to system wide strategic priorities in a consistent and cost effective way that supports the tailoring of delivery at Place, town and neighbourhood level to drive improvements in health inequalities and place more focus on prevention and early intervention.

SECTION 4: National Condition 2: Enabling People to Stay Well, Safe and Independent at Home for Longer

SECTION 4.1: Overall Approach

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

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The evolving structure of the health and care partnership alongside the continued incorporation of population health data through Graphnet technology assists Local Joint Commissioning Groups 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.

Across the county, BCF funding has been used for prevention and self-management using a strengths-based approach which recognises the assets of the individual:

- 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 locally commissioned service, playing a central role in the development of primary care network wide multidisciplinary teams, 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 and social care, and the voluntary sector.
- The BCF has also seen considerable investment in Reablement. Reablement services, delivered countywide but implemented to meet specific Place based requirements include the use of

domiciliary care services (home based care) who focus specifically on collaborative reablement supported by in house reablement teams.

Care within the home services are already jointly commissioned between Surrey County Council and NHS Continuing Healthcare (CHC) and as such are well placed to respond to fluctuating demand and different models of service delivery. In order to strengthen our ability to keep people safe, well and independent at home for longer much of the BCF funded services at Place need to align to strategic service development; we have commissioned hospital admission avoidance hours, bridging services and block care hours from the domiciliary care market that compliment reablement already in place.

BCF continues to address inequalities through its strategic alignment to Surrey Heartlands and Frimley Health and Care's ICS strategies, 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. BCF funding continues to be allocated to projects/services directly addressing health inequalities, for example:

- 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 primary care networks, 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 develop 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 development programmes (Growing Health Together and personal development services such as Wellbeing Prescription) enable individuals to engage in community networks thus creating a sense of resilience. Partners within the Local Joint Commissioning Group 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.

In 22/23 Surrey Downs supported more than 20 organisations with seed funding benchmarked against BCF metrics for new projects that we anticipate will lead to sustained benefits through 2023-25. Key priorities being to encourage connectivity and reduce isolation (particularly following Covid), to

develop skills among young people; and to provide bereavement support (given the greater demand as a result of covid-related deaths).

North East Hampshire and Farnham are planning targeted work on fallers this year by looking at increasing activity levels and reviewing what services are available. They are considering expanding the service that currently runs throughout the rest of Surrey into Farnham (as Farnham is not covered at present). They are planning to use population health data to identify where higher incidences of fallers occur and encourage ideas from the local community on how they can invest in services to help.

SECTION 4.2: Capacity & Demand Approach for Intermediate Care in the Community

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

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National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our overall approach to capacity and demand planning within Surrey is continuing to develop and our aim to have a Capacity and Demand Plan which is live and actively used by operational teams across the county. The first step has been developing the Capacity and Demand Assessment submitted as part of this plan and we intend to progress towards a more comprehensive approach at Place level during 2023-25. For this submission, we have based our assessment on Surrey Heartlands data and added an additional 15% to estimate Surrey wide figures which has been agreed with system colleagues. As numbers for the voluntary sector are not collected, we have made an assumption that these are 3% of total capacity based on local knowledge and available evidence.

We have used this initial Capacity and Demand Assessment to inform what services we plan to invest in over the coming years, and as we amend and continue to improve its outputs, we will ensure our BCF investments meet the needs of our local populations. Our plan shows a predicted increase in Pathway 1 and Urgent Community Response demand. The schemes we are investing in at Local Joint Commissioning Group level will attempt to meet that predicted demand, for example some of the investment into assistive technologies or Pathway 1 Discharge to Assess investment.

Most referrals for local authority funded services comes from community referrals. However, reablement sees demand for services generated from acute hospital discharges at around 80% of current capacity. Coupled with this, additional bed based, and home care capacity was established (under Discharge to Assess) to also meet the demands of hospital flow.

Learning from this demonstrated three main areas of challenge:

- Self-funders, out of county placements and complex needs placements cause delays and bed blocking in hospitals.
- Focus on prevention would be more beneficial than continuing focus on 'back door' discharge approaches and capacity.
- Intermediate and primary care (including clinical services) need to be available to manage effective access to, and utilisation of, existing and new capacity.

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In Surrey, approximately 65% of patients needing discharge are self-funders and we support them through a number of ways:

- Adult Social Care fund six weeks of home-based reablement support to all patients (regardless of funding status) preventing the need for care home/escalation of care which could delay discharge.
- Three of the Surrey acute NHS Trusts (Royal Surrey Foundation Trust, Surrey and Sussex Healthcare Trust, and Epsom and St Helier University Hospital Trust) run the Care Home Select (CHS) programme. Once patients are identified as self-funders and having capacity, the hospital engage CHS to identify a suitable care home on behalf of the families and arrange the placement. The hospitals fund this directly with CHS (£600/pt).

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Self-funders create challenges to effective discharge due to the fact Adult Social Care have no legal duty to fund ongoing care and support arrangements for self-funding patients once they have been identified as medically fit for discharge. In addition to this, acute trusts and the ICS invest a significant amount of time and resources into supporting self-funders as the Choice Policy is difficult to enforce (and has been for years) for patients who are medically fit for discharge. There needs to be a solution which ensures the safety and best outcomes for the patient but supported by statutory levers. The high level of self-funders in Surrey makes this a particularly challenging problem locally.

We are working with the national team to understand how NHS England and the Department of Health and Social Care can support systems to improve the flow of patients who are self-funders out of acute trusts and into an appropriate place of residence.

SECTION 4.3: How BCF is Adapting to Support Delivery & Expected Impact on Metrics

(Enabling People to Stay Safe, Well and Independent at Home for Longer)

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

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A key priority for Surrey County Council adult social care is transforming Surrey's reablement offer to support all people, from the community and following hospital discharge, who would benefit from personalised support to achieve their goals and to gain or re-gain skills, confidence and independence.

To deliver this ambition the future approach to reablement services is being developed and the recommissioning of a transformed collaborative reablement offer will take place later in 2023 that ensures a greater emphasis on working with community referrals as well as continuing to support discharge.

BCF funded services, such as home from hospital services and TEC, currently, and in the future, will continue to compliment reablement and home-based care hospital avoidance schemes and the delivery of core intermediate and primary care services to ensure a clear pathway for patients / residents wishing to return home. This will also be essential in developing better pathways back to someone's residential and nursing care home as appropriate.

There are a number of ways the BCF is continuing to support this national ambition, including:

- The BCF funds reactive services through integrated community services. One of which is the integrated @home service that support people to remain at home as an alternative to an admission or extended hospital stay.
- BCF funding helps support the integrated team that deliver wrap around care for over 65 residents with staff made up of health and social care.
- Evidencing a measurable impact for residents, with reduced emergency department attendances non-elective admissions for Surrey Downs residents to local acutes.

The future focus for BCF funding and integrated commissioning will be to focus on delivering against this objective in the following ways:

- Establishing a longer-term Discharge to Assess offer.
- Focusing on a new model of reablement targeted at prevention.
- Segmenting market provision to flex service capacity at Place and meet fluctuating demand driven predominantly by hospital pressures, but also focusing on prevention.

- Ensure pathways for individuals to return / remain at home are clear and robust, considering care within the home services, transport, discharge planning, medication, intermediate care integration with models of social care delivery and use of technology enabled care as examples.

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SECTION 5: National Condition 3: Provide the Right Care, in the Right Place, at the Right Time

SECTION 5.1: Overall Approach

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

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From 2023 Surrey County Council will be undertaking work as part of a regional Assistant Directors of Adult Social Services (ADASS) commitment to NHS England South East Regional Delivery Unit. This will explore a more strategic approach to discharge across the region. There are 4 workstreams (as below) and Surrey County Council will be involved in the Models of Care work. Outputs of this regional work will feed into our system approach to discharge in the future.

1. **Metrics** - Identify 10 metrics across the health and care sector used to measure flow and discharge.
2. **Strategic Surge Response** - Strategic multi-agency surge plan taking account of commissioning, workforce, funding, and pathway challenges that is preventative in nature, responding to peaks in demand in a co-ordinated, cost-effective manner.
3. **Workforce** - A workforce strategy across the region that resolves challenges to rates, ways of working and deployment.
4. **Models of Care** - Develop and test new models of care that are joined up and seamless.

The metrics referred to have not yet been developed. Surrey County Council are directly involved in the models of care workstream, and we will be kept abreast of the work through the ADASS network and await the outputs from the metrics workstream with interest.

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 BCF. 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 both at Place and System level. We continue to emphasise personalised care across the system. We have an ICS Personalised Care Steering Group, a Personalised Care Lead (at associate director level) and hospital discharge personal health budgets are organised and managed at Place level.

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Surrey is continuing to operate a Discharge to Assess model across the whole of Surrey covering both the Surrey Heartlands ICB and Frimley ICB footprints. It is currently estimated that approximately £16m will be required on Discharge to Assess services commissioned to facilitate discharge of people from acute hospitals into support arrangements in their own homes or step-down services in care homes.

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The £7.6m of Adult Social Care Discharge Fund (ASC DF) grant monies being received by ICBs and allocated to the Surrey area combined with Surrey County Council's ASC DF grant that are being pooled in the 2023/24 Better Care Fund will fund a proportion of the total £16m (approximate) expected expenditure on D2A services in 2023/24. The remaining £8.4m (approximate) of estimated Discharge to Assess expenditure in 2023/24 will be funded out a combination of some core BCF monies and funding held outside of the BCF including some non-recurrent funds. The Discharge to Assess costs funded by the ASC DF are all additional in terms of representing services that have been purchased to support discharge utilising the grant funding outside of base budget expenditure across ICBs and the Council.

Surrey's ASC DF grant funding in 2023/24 represents a reduction of £1m from the £8.6m received in 2022/23 due to changes in the way funding for local authorities was allocated between authorities which resulted in Surrey County Council receiving a lower allocation.

The 2023/24 ASC DF grant funding pooled in Surrey's BCF in 2023/24 will be funding additional Discharge to Assess capacity that we would otherwise be unable to fund through our broader recurrent funding. Similarly, the expected increase of up to £12.2m of ASC DF grant monies to be pooled in Surrey's BCF in 2024/25 will fund additional capacity that we would currently be unable to fund through recurrent funding sources.

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

- The implementation and 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 additional reablement and therapy provision. There has been significant investment into our community nursing teams, including into In-Reach

community nursing roles within the acute hospital. These roles have helped to ensure that more patients, and 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.
- 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 service is available for pathway 1 and pathway 0 hospital patients. Volunteers contact all discharged patients 3 days post discharge and provide assistance 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 pool capacity and reduce delays. For example, the co-location of reablement and rapid response colleagues in East Surrey is firmly established.
- BCF has agreed to support a new Discharge to Assess and Recover pilot which is a rapid response 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 a multi-disciplinary 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.

Planning to support this demand and the complex discharges is ongoing. The BCF has dedicated investment in the Discharge to Assess and Recover model, 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.

There is now a daily Surrey System oversight call with all NHS providers reporting current positions within a collaborative support and problem-solving ethos. Mutual support can be provided, and patient-level solutions can be identified with call upon BCF funded services as necessary.

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SECTION 5.2: Capacity & Demand Approach for Intermediate Care to Support Discharge from Hospital

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
  - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

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As outlined previously, our overall approach to capacity and demand planning within Surrey is continuing to develop and our aim is to have a Capacity and Demand Plan which is live and actively used by operational teams across the county. The first step has been developing the Capacity and Demand Assessment submitted as part of the BCF Plan and we intend to progress towards a more comprehensive approach at Place level during 2023-25. For this submission, we have based our Capacity and Demand Assessment on Surrey Heartlands data and added an additional 15% to estimate Surrey wide figures which has been agreed with system colleagues. As numbers for the voluntary sector are not collected, we have made an assumption that these are 3% of total capacity based on local knowledge and available evidence.

Learning from commissioning and operational practice of the 2022/23 ASC DF has been incorporated into Discharge to Assess planning to ensure funding is deployed to maximum effect. This includes ensuring block purchased services are commissioned as closely in line with actual discharge volumes to facilitate timely discharge and limit any under-usage of blocks.

We anticipated a mixture of need, including both care at home and in care homes. We accordingly commissioned a variety of care offers based upon meeting the full spectrum of people's needs. The situation has been very fluid and influenced by a number of factors including availability of care, acuity of patient, declared operational pressures escalation level (OPEL) of hospitals etc. There have been some challenges in securing timely, safe and appropriate discharge for arrangements for adults and older people with challenging behaviour. We have also recognised, as a system, that we need to take forward a joint approach to managing the discharge (from general acute hospitals) of people with poor mental health who are under 65. In addition to this, we have recognised a need to take discrete

actions regarding training and practice for anyone who is eligible for Mental Health Act s117 aftercare and is awaiting discharge from general acute hospital.

We have adjusted our commissioning arrangements accordingly and plan to have more robust arrangements in place during 2023 to be able to swiftly flex up and down the service required based upon need. We will be using commissioning activity to minimise potential voids in discharge services, making the BCF money go further. Recently, we are getting clear communications from the domiciliary care market that they have more availability of staff. Therefore, we will be going to market to seek relevant cost efficiencies and additional capacity to continue to expand our Home First default position.

We are also taking learning around patients who have delirium or are non-weight bearing and awaiting rehabilitation.

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Integrated care will be viewed at Place to ensure greater alignment with market management activity and capacity modelling / delivery, which is well underway for adult social care commissioned provision, most significantly, Discharge to Assess. This will see opportunities to align existing BCF contributions to support demographic need at Place and develop a more robust integrated care offer where the system requires this. Governance is being strengthened to ensure system alignment and clarity of decision making.

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SECTION 5.3: How BCF is Adapting to Support Delivery & Expected Impact on Metrics

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

We have recently worked closely as Surrey County Council and ICB Partnership to undertake evaluations of all ICB Place systems in Surrey to consider:

- How we have approached discharge to usual place of residence
- Variation
- Recommendations to ICB Executive going forward.

In 2022-23 there were a variety of options available to patients being discharged from hospital. Broadly, people could either be discharged to a bed-based care facility or back to their own home with care and support provided.

As far as the bed-based offer was concerned, people could:

- Return to the care home that they were admitted from, subject to the care home still being able to meet their needs.
- Move to a different care home (with a different registration category) if their usual care home residence could no longer meet their needs.

- Move temporarily to a step-down facility (community hospital or care home) whilst further health and social care assessments were undertaken.

The return to one's own home offer consisted of the full spectrum of services listed in 5.1 and involved additional BCF investments into primary care, home-based care including reablement.

Our ambitions around discharge for 2023-25 include:

- Delivering a consistent hospital discharge offer across all Places which is focused on Home First with the patient, carer, and family at the centre of the pathway which can flex up and down as appropriate, with surge.
- Agreeing a shared Discharge to Assess system metrics.
- Improving whole system commissioning processes which support Surrey County Council adult social care commissioners to lead on system wide market engagement and market shaping, with closer working at Place, to deliver tailored support in the right place at the right time with the right system balance.
- Ensuring that BCF budget supports System and recognises Place.
- Developing Place delivery models aligned to demand modelling and have these agreed by the Urgent and Emergency Care Board.
- Ensuring complex care pathways are reviewed by Place with Discharge Cell oversight, aligned to mental health transformation.
- Ensuring education and understanding of Discharge to Assess across the system is available for patients, Carers, and staff.
- Improving engagement and risk management with community, medicines management, Health Watch, the voluntary, community & social enterprise sector, Surrey Care Association, and primary care.
- Ensuring integration and wrap around with Virtual Care and Virtual Wards which is resourced and scaled up.
- Ensuring a community data set that includes hospital discharge is approved by Place and owned by System.
- Ensuring governance at Place and System are aligned.

In line with the ambitions set out in NHS England Delivery Plan for recovering Urgent and Emergency Care Services, we have established (for 2023 and beyond) a dedicated Improving Discharge Workstream as part of the Surrey Urgent and Emergency Care Board's work. This has system leadership from across the ICS.

In addition to this, we will ensure that people with delirium or who are non- weight bearing do not get delayed in hospital. Use of BCF assists as a funding mechanism to secure timely discharge for these cohorts of people. We have committed to use our existing learning to consider jointly developing a wider Delirium or non-weight bearing pathway that is consistent across the ICB area. This work will be progressed via the Urgent & Emergency Care "Expanding Care Outside of Hospital" workstream.

We know that 93% of non-elective admissions in Surrey return to their usual place of residence following discharge from hospital. We will undertake a comparative review to consider this statistic against other systems and to identify and understand any significant variation within the Surrey system.

SECTION 5.4: Progress in Implementing the High Impact Change Model

(Provide the Right Care, in the Right Place, at the Right Time)

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

The Surrey system has used the High Impact Change Model as a driver for some time. The key focus now is the Urgent and Emergency Care Recovery plan that incorporates all of this. There is a specific workstream we are leading on under the Urgent and Emergency Care Collaborative which incorporates the High Impact Change Model. The key to this is to expand and enrich our discharge data to understand both demand but also the impact of any discharge improvement. We have a discharge dashboard within the SHREWD IT platform that is in development.

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In summary, the Emergency Care Recovery Plan aims are about:

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- Improving joint discharge processes via roll out of Transfer of Care Hubs with improved assessment and planning processes.
- Promoting principles that underpin the Discharge to Assess model.
- Highlighting where capacity does not match demand levels across all the pathways and taking any remedial action.
- 80/20 Discharge split at weekend.
- Embedding, where possible, the work completed by Impower consultants regarding Discharge and Flow across Surrey.
- Developing a care home/domiciliary care dashboard.
- Scaling up intermediate care – utilising the evaluation of the Frontrunner national standard for rapid discharge into intermediate care.
- Scaling up social care services by working with local government and social care providers to optimise access to social care.
- Undertaking further work with Continuing Health Care to ensure patients with the most complex needs have similar experiences and outcomes to the general inpatient population when they are ready for discharge.

What we expect:

- Improvement in Criteria to Reside performance.
- To continue to embed the 10 best practice interventions in 100-day challenge.
- Increased flow into intermediate care.
- Increased access through Adult Social Care.
- To reduce bed base Length of Stay for medically fit.
- Robust discharge data to evidence.
- Improve 80/20 performance.
- Reduced variation in performance.
- Established process for Personal Health Budgets in Integrated Care System.

93% of Surrey residents return to their usual place of residence. There is still some variation at Place and we are committed to exploring this variation further in the future. We have made additional

investments into health & social care community teams for D2A from BCF. We have also invested in ring-fenced domiciliary care to achieve this objective. We do not complete continuing healthcare assessments in hospital. The implementation of Criteria to Reside has had been widely adopted by consultants & this is also having an effect. We are rolling out of Transfer of Care Hubs with improved assessment and planning processes. This workstream will also highlight where capacity doesn't match demand levels across all the pathways.

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SECTION 6: BCF Support to Unpaid Carers and Care Act Duties

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF funding is utilised to support advocacy services (instructed and non-instructed) throughout Surrey and investment in the Safeguarding Board operation. A contribution is also made towards the operation of domiciliary care, known as Care within the Home, which is a joint arrangement between Surrey County Council and NHS Heartlands continuing health care which also operates on behalf of Frimley.

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This investment supports the overall ambition for people living in Surrey to be supported to remain independent, stay at home, strength gain and reable where possible. These contributions facilitate, in part, Surreys' ambition to ensure people have access to the support they need from providers of good quality operating under contractual arrangements within the integrated system.

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BCF funding is also spent on information and advice services, provided through Age UK Surrey, which ensures people can access support for their health and wellbeing, including realising any entitlement to benefits, and can make informed decisions about their short and / or long-term health and care needs.

Surreys' Stroke Recovery service is also funded through BCF and is commissioned from Surrey adult social care on behalf of both Surrey Heartlands and Frimley systems.

All of these programmes funded by the BCF enable the duties of the Care Act to be delivered.

Supporting unpaid carers

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

A ringfenced budget has been created within the BCF specifically to address the support needs of Carers, implementing the co-produced Surrey-wide strategies for adult Carers and for young Carers. The budget supports the long-standing and well-established Integrated Carers team. This comprises Surrey County Council and Surrey Heartlands ICB employed staff and is hosted within Surrey County Council under the Partnership agreement between the two organisations. It also works in partnership with Frimley ICB. The team work on a range of projects and programmes to improve outcomes from unpaid Carers. One theme from the strategy was around supporting working Carers and to progress this a staff Carers' survey will be launched in Carers' week in June 2023 across the System; Carers' champions have been appointed in Surrey Heartlands ICB; staff sessions on managing carer burnout have been set up and there are plans for a Surrey employers event to focus on supporting working Carers.

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

A review of the specific support needed by Carers of someone with mental health needs has led to service specifications being co-produced with Carers and an approach to the provider market is planned this summer.

There is also an innovation fund to address issues that arise and that are not otherwise addressed in the specifications for the system wide commissioned services, allowing smaller scale, Place, town or neighbourhood specific initiatives to be developed or for new approaches to supporting Carers to be developed and tested out to inform future strategies.

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.

SECTION 7: BCF Support to Housing, including the Disabled Facilities Grant (DFG)

SECTION 7.1: Strategic Approach to Housing to Support Independence at Home

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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Surrey County Council works strategically with its 11 district and borough councils and has a clear commitment to the importance that housing and housing support plays in promoting and supporting independence. This commitment is set out in the recently published Housing Strategy (DRAFT Strategy for Housing Accommodation and Homes - Cabinet Report - Oct22 MC.pdf (surreycc.gov.uk)) and through a range of specialist housing strategy documents that form part of Surrey County Council's Accommodation with Care and Support Strategy and transformation programme. This programme includes three strategic areas of focus with clear and ambitious targets to fundamentally change the range of accommodation with support available to Surrey residents as follows:

- Extra Care Housing – to delivery 725 units of Extra Care Housing by 2030
- Supported Independent Living for people with Learning Disabilities and Autism
- Supported Independent Living for people with mental health support needs.

- **ECH 2019 Strategy** - 16. Accommodation with Care support Cabinet report July 2019.pdf (surreycc.gov.uk)
- **SIL LD 2020 Strategy** - Supported Independent Living Report- Cabinet.pdf (surreycc.gov.uk)
- **SIL MH 2023 Strategy** - PART 1 CABINET REPORT - DELIVERY STRATEGY FOR MODERNISING AND TRANSFORMING ACCOMMODATION WITH SUPPOR.pdf (surreycc.gov.uk)

The Disabled Facilities Grant (DFG) is paid to district and borough 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 occupational therapists being involved in ensuring provision is reasonable and appropriate (Guildford and Waverley). District and boroughs 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 Local Joint Commissioning Groups 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 district and borough councils attend every other meeting (six each year) to provide essential local knowledge.

In addition, Integrated Care Partnerships (ICPs) will be a delivery forum for issues which require a co-ordinated approach. In attendance will be district and borough councils, health and VCSE representatives. This enables 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.

SECTION 7.2: Regulatory Reform Order 2002

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

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If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

No

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SECTION 8: Equality and Health Inequalities

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

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System Priorities and Operational Guidelines Regarding Health Inequalities in Surrey

The BCF in Surrey is aligned with both BCF national policy guidance and the HWB Strategy. In Surrey, as nationally, we continue to focus on the health and wider inequalities that persist in our populations and this is driven by the focus of our local health and wellbeing strategy which explicitly states an ambition to reduce health inequalities across Surrey. Building on the rapid needs assessment done during the COVID-19 pandemic, and the Joint Strategic Needs Assessment more broadly, this focuses on a number of Priority Populations of identity and geography including the 21 Key Neighbourhoods that relate to the Index of Multiple Deprivation.

These have been adopted as Priority Populations in the refreshed Health and Wellbeing Strategy and are increasingly being used to focus activity around health ine qualities across organisations, including within the BCF programme. For example, Carers and Young Carers (one of the Priority Populations of Identity) are supported through the BCF Carer's Budget as outlined in section 6. BCF support to one of the Key Neighbourhoods in Farnham is outlined as a case study below. Our local Integrated Care Systems (ICS) have both adopted a further focus on inclusively supporting those in greatest need through working with communities and across the NHS, local authorities, and other partners through programmes that are delivering a focus on CORE20 plus 5.

In Surrey Heartlands, the Equality and Health Inequality Workstream consider the Priority Populations as set out in the HWB Strategy. They also consider the issue of equality and health inequalities for our citizens, patients, and also the workforce that supports their care. The role of the Equality and Health Inequalities Board is to focus on our response to the NHS Operational Planning Guidance which outlines five priority areas for tackling health inequalities.

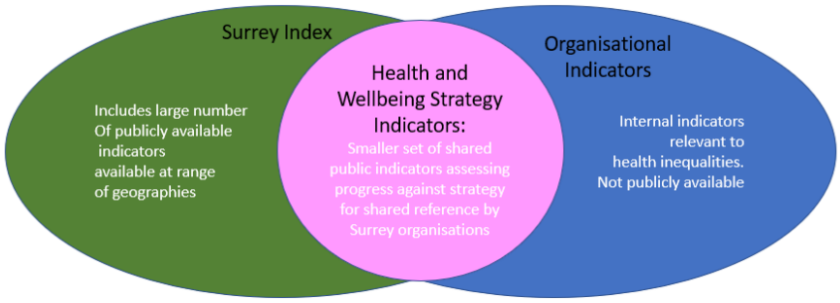
In Frimley, the Local Plan ambitions include reducing inequalities. A range of insights have been gathered to identify specific cohort groups across communities where further action is needed. This work cuts across all areas of the ICS plans including elective recovery, mental health transformation and community redesign. Locally, population health management approaches, data segmentation and risk stratification have also been used to provide insight into those facing the greatest health

inequalities and/or with the most complex needs that would benefit from local, targeted, personalised and multidisciplinary support.

Key to all of this work on health inequalities is our need for continued and greater engagement with communities which is represented through the Key Principles of working with communities in our Health and Wellbeing Strategy. The VCSE sector has 3 members on the HWB Board.

Key Changes for 2023-25

A key change during 2023-25 will be the introduction of a new HWB Strategy Index for Surrey to enable a broader focus across health, wellbeing and the wider determinants of health. It is intended that the new metrics will be used by organisations alongside their internally available organisational indicators, such as those being reviewed regularly by the Equalities and Health Inequalities Board at Surrey Heartlands ICS.



Having a common set of publicly available indicators will aid our understanding of our collective progress against outcomes that have many contributing factors. This common set of indicators will also be reflected within the developing refresh of the JSNA chapters and be complemented by the additional detailed health data that is coming through population health management. Wherever data is available, the indicators will be available to be interrogated at the lowest possible geographical level. This will enable the BCF to take a more targeted approach to reducing health inequalities across Surrey.

How Equality Impacts of the Local BCF Plan have been Considered in Surrey

When developing BCF plans, Local Joint Commissioning Groups take into consideration strategic commitments to reduce health inequalities in relevant Place-based plans, ICS operational plans, district and borough and Surrey County Council strategies.

Rather than an overarching equalities impact assessment being in place for the high-level BCF plan, all commissioned programmes locally (including those in the BCF) include specific equality impact assessments to not only ensure compliance with the Equality Act 2010 but more importantly ensure all opportunities for access for those with protected characteristics are maximised.

How Inequalities are Being Addressed by the BCF

In line with our overall HWB Strategy, our approach for 2023-25 will include projects that are designed to reduce inequalities. We have an included a case study of healthy eating courses from Farnham as an example:

Case Study: Healthy Eating Courses in Farnham, Surrey

We recently identified a specific area of deprivation in Farnham and invested in healthy eating courses to improve diet, reduce food wastage, improve life skills, promote physical activity, reduce loneliness, and address cost of living crisis by teaching cost effective use of energy and food. The community centre also acts as a warm space within the winter months. The aim is to use this initiative to bring those who might not usually use the community centre into the space to see the range of broader offers including mental health support and citizen's advice bureau.

The project is centred on the population of Sandy Hill estate in Farnham. Sandy Hill has been identified as being within one of the Key Neighbourhoods in Surrey by the HWB Strategy. The Farnham Health Inequalities Group are working to promote and develop the existing work of Hale Community Centre based on the estate, and recently have linked with The Health Creation Alliance in this aim. The area is poorly served by transport links and lies on the outskirts of the town with poor facilities apart from some large green spaces, and an active community centre. Work to date has identified a lower level of physical activity for Sandy Hill residents than in surrounding areas, a desire to eat more healthily and concerns regarding financial stressors.

More broadly, any new funding requests for North East Hampshire and Farnham Local Joint Commissioning Group, will now have to show how the population health needs of the local population will be addressed.

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