Surrey Countywide Better Care Fund Plan 2021/22

1. Executive Summary

Surrey's three strategic priorities for the Better Care Fund continue to be:

- Enabling people to stay well - 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
- Enabling people to stay at home - 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 newly BCF Surrey-wide and local place-based funded activity for 2021 – 2022 includes:

- Across Surrey £1,000,000 for Discharge to Assess staffing
- £500,000 to support the Surrey All Age Autism Strategy
- 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 Surrey Heath
    - Commitment to support homelessness case worker in Surrey Heath

In Surrey, as nationally, Covid-19 has further exposed some of the health and wider inequalities that persist in our populations. Surrey's Health and Wellbeing Strategy has been refreshed to include a strengthened focus on health inequalities. This is reflected in work developing across system partners to better target and reduce health inequalities. Surrey's Better Care Fund Plan for 2021 - 2022 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.

2. Introduction and Involvement of Stakeholders

Surrey Health and Wellbeing Board covers the geography of a complex health and care system. Surrey has one county council, two CCGs, eleven district and borough councils, five acute hospital trusts, one mental health trust, multiple community care providers and well over 120 GP surgeries. In addition, there are a wide range of other providers, including voluntary and community organisations that deliver essential health and care services to Surrey residents.

The two ICS footprints covered within Surrey's Health and Wellbeing Board are:

- Frimley Health and Care - covering the geographic areas of Ash, Farnham and Surrey Heath (excepting Chobham and West End which are covered by Surrey Heartlands)
- Surrey Heartlands - covering the geographic areas of East Surrey, Guildford and Waverley, North West Surrey and Surrey Downs

The Better Care Fund in Surrey has local commissioning arrangements that operate through Local Joint Commissioning Groups (LJCG). As with previous plans, the Surrey 2021 – 2022 BCF plan continues to have input from the LJCGs, Surrey Heartlands CCG, Frimley CCG and Surrey County Council partners. It takes into consideration relevant ambitions and strategies across Surrey, including Urgent Care and Emergency Care Plans.

BCF projects are aligned to the Surrey-wide BCF priorities and local plans, including the county's Health and Wellbeing Strategy, local District & Borough Council strategies, ASC commissioning intentions, and NHS Long-term Plan priorities.

All LJCGs include core membership from the CCG and Surrey County Council. LJCGs each develop their approach to engagement on plans and activity with partners at a place-based level and these include relevant local VCS and District and Borough Councils. Many also have representation from relevant local A&E delivery boards or are developing links via relevant governance routes.

Examples of this local place-based approach include:

- **Guildford and Waverly LJCG** meets monthly. Wider partners, including the two Borough Councils, attend on a quarterly basis. Commissioning actively involves VCS organisations and supports with applications for BCF. Outcomes of BCF-funded schemes are shared through forums such as the Local A&E Delivery Board (LAEDB) and the Alliance Finance and Assurance Committees to ensure partners are aware of the plan.
- **Surrey Downs and East Surrey LJCG** have regular meetings with Districts and Boroughs. This discussion shapes commissioning decisions and has led to the adoption of an outcomes framework that brings together the strategic commitments published in strategy documents. Key members of the LJCG regularly engage with local stakeholders both through officially contracted services and via local forums including area network meetings. At a wider place-based level, East Surrey is working closely with an external organisation to facilitate the development of a strong, effective, place-based partnership. This includes engagement with local residents, VCS, and other statutory and local service providers.
- The **Surrey Heath LJCG** meets bi-monthly with core members from SCC, Surrey Heath Borough, Public Health and Surrey Heath CCG staff. Through this forum, engagement with wider stakeholder groups is organised using other partnership meetings or through invitation for specific items to the LJCG. The priorities for the local BCF activities are informed by discussions in these wider partnership meeting. Within Surrey Heath there has been a recent focus on strengthening the involvement of the Borough Council as a core

member of the LJCG. Benefits are already being seen in terms of better understanding of the opportunities around the Disabled Facilities Grant and greater integration around particular local population cohorts, for example those who are homeless. Senior Borough representatives are attending all bi-monthly meetings and significantly adding to the quality and effectiveness of joint planning, delivery and decision-making.

North West Surrey meet monthly with all key partners as an Alliance Board. This is a formal placed-based partnership that includes four District and Boroughs, Voluntary Sector, NHS providers and commissioners. In addition, the focus on outcomes required from the BCF are managed through the **Local Joint Commissioning group** where opportunities to be innovative (maximising the use of the voluntary sector and developing relationships with Housing, and housing improvement agencies for the use of DFG) are explored and actioned. Avoiding unnecessary hospital admissions and supporting discharge by the use of District and Borough Discharge Officers is making a difference especially for patients on pathway 0.

As mentioned, our place-based arrangements are supported by individual A&E Delivery Boards that are coordinated through the Integrated Care partnership (ICP) Urgent Care Board. As part of our Urgent Care 10 Point Plan, we have focused the governance arrangements to support patients across the system, including through daily 'Gold Calls' to ensure support for specific areas (where required) through mutual aid. This allows for additional attention and aid to be given to areas who may require support in areas such as critical care and length of stay. The BCF and its commissioned services have been integral to this work.

Finally, the 2021/22 Better Care Fund plan is shared with Surrey's Health and Wellbeing Board for approval and discussion of future pro-active planning opportunities. The Board's membership includes representatives from Surrey County Council, place-based partnerships, ICSs, CCGs, District and Boroughs, HealthWatch Surrey, the VCS, the University of Surrey and the Police and Probation services.

3. 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.

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. The LJCG also oversees the delivery of local initiatives. The remit of LJCGs includes oversight of the performance of schemes.

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.

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.

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.

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.

In 2021/22, to reflect the impact of the pandemic, the Health and Wellbeing Strategy and priorities have been refreshed to strengthen the focus on health inequalities during COVID recovery and also provide a greater focus on the wider determinants of health. This has also included an enhanced understanding and definition of priority populations of identity, alongside those based on geographies with the highest levels of deprivation.

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

- Priority one: Supporting people in Surrey to lead healthy lives
- Priority two: Supporting the mental health and emotional wellbeing of people in Surrey
- Priority three: Supporting people in Surrey to fulfil their potential by addressing the wider determinants of health

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. Whilst only recently agreed, 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. The health inequalities agenda within the Health and Wellbeing Strategy is covered more comprehensively later in this narrative plan.

4. Overall Approach to Integration

Surrey's three strategic priorities for the Better Care Fund continue to be:

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Integrated working is a key theme across Surrey and is integral to our ongoing response to mitigating demand and supporting earlier intervention and prevention. This wider approach incorporates addressing pressures, including those particularly seen during winter months. Integrating care is also an important way in which we are wrapping care around the person to ensure the support and services that meet their needs are joined-up.

Across the county, there has been a focus on the development of integrated services. This started with services for older people but we are now enhancing the integration in services for working age adults too. Work is continuing to build on and extend the remit of existing Integrated Care Teams that include community health, social care, voluntary organisations and primary care. These teams 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. Social care, community health and the wider team continue to work together to deliver services to keep people out of hospital and to return them home as quickly as possibly following an acute admission.

Alongside this system-wide work, place-based approaches ensure service delivery is tailored to local populations. Locally, through developing Place-Based Partnerships and LJCGs, stronger partnerships continue to develop between health, social care and VCFS groups.

In our 2020/2021 BCF end of year return, we reported how established relationships through the Local Joint Commissioning Groups aided effective joint-working and decision-making from the beginning of the COVID – 19 pandemic and this has continued in 2021/22. The Groups gave transparency and governance to decisions that needed to be made quickly and aided some of the very challenging issues to be addressed and resolved.

Strengths-based, person-centred care remains at the heart of service delivery in Surrey and is an essential way in which we are supporting residents to lead more independent lives and not rely on long-term support services. The aim is to support people in their own homes, providing reablement/rehabilitation and short-term services that maximise independence.

Whether on a county-wide basis, an Integrated Care System footprint, a Place–Based Partnership level or through local Primary Care Networks, Surrey's Better Care Fund continues to be used to drive organisations to work across boundaries to deliver outcomes for Surrey residents. All 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 which reflect the developing local Health and Wellbeing Strategy. Individual BCF service contracts ensure patient

choice is at the heart of service delivery and contract reviews ensure KPIs reflect patient engagement with services.

The key actions that are being undertaken across Surrey for 21/22 to embed person-centred, integrated care models are:

- Putting the organisational infrastructure in place so that partners can join up to tackle the wider determinants of health (for example housing).
- Implementing an effective Information and Advice Service to help residents to navigate the health and care system.
- Ensuring providers are working together across the system to develop person-centred workforce planning and relevant training. Across the system, our staff are being trained in trauma-informed and strengths-based approaches to care.
- Risk stratification tools in place to ensure proactive case finding is becoming more commonplace for better targeting and prioritisation of patients using data and intelligence.
- Ensuring proactive/anticipatory care planning is more joined up.
- Integrating Intermediate Care between the NHS community services and Local Authority Reablement Service as a component of community-based care models.
- Investing in appropriate technology in care and digital solutions that drive integration and offer greater independence for patients.
- Embedding joint leadership roles. For instance, Surrey Heath's joint leadership roles across health and social care and their 'one team approach' are helping to secure an integrated approach to improving outcomes for people being discharged from hospital.
- Joint client assessments are being put in place. As an example, clinics between Occupational Therapists and Council Grants Officers are allowing client clinical needs to be assessed while also providing early guidance on financial eligibility for DFG or other assistance.
- Admission avoidance schemes are being successfully linked up, for instance frailty programmes and falls prevention work.
- We are strengthening our strategic approach to key issues and initiatives such as Social Prescription and Community Inclusion. Approaches have developed over time in each locality, however there is scope to focus to a greater extent on addressing inequalities in health, early intervention, the prevention of hospital admissions and facilitating discharge while remaining tailored to local need.
- Taking an alliance approach to delivery that capitalises on strengths across the system. For instance, the new children's Emotional Wellbeing and Mental Health Service launched in April 2021 and is delivered through an alliance of NHS and third sector providers.
- Integrated MDT approaches are being used to target and review patients proactively identified as most at risk of crisis. By the end of the year, across Surrey Heath and Farnham, a digital hub will be in place for professionals across the system to case manage and monitor MDT patients.

To support continued development of successful joint commissioning across Surrey, key strategies are co-produced with joint priorities articulated that form the basis for commissioning decisions. This year, Surrey County Council has been working with NHS and wider system colleagues to develop a Commissioning Strategy for Older People which sets out our ambitions to 2030. In addition, our Surrey Carers Strategy 2021-2024 was launched in September 2021 and will ensure Surrey is a place where carers are recognised, valued and supported. Our aim is that across Surrey, carers are respected as partners in care who have a strong voice that influences improvement and how we work together across the system.

We are also currently co-producing a Physical and Sensory Disabilities Strategy. This will respond to feedback from people across Surrey and from practitioners in social care that care pathways need to be reviewed and customer journeys improved. The Strategy stresses the need for choice and control and for personalisation, facilitated by a greater uptake of direct payments. Joint commissioning decisions going forward will reflect these priorities.

Joint commissioning across Surrey is being supported by the development of local clinical networks where expertise is shared and pooled. Currently in Surrey, Primary Care Mental Health services are strengthening local clinical networks between GPs, social care professionals and mental health professionals.

We recognise the importance of Direct Payments as a tool for facilitating greater independence, choice and control for Adult Social Care (ASC) users. We are therefore currently co-producing with our key stakeholders a Direct Payments Strategy, with the overarching aim of increasing take-up. Workstreams in the delivery plan will include streamlining the customer journey from considering DP as an option to accessing support. This will require streamlined care pathways and is interwoven with our commitment to strength-based practice.

Our strategic approach to Community Inclusion is currently under review. We recognise that our offer and range of preventative initiatives makes an important contribution to the extent to which individuals are able to lead meaningful, engaging lives. A range of options are being developed that will facilitate users to access the appropriate level of support that reflects their potential independence, including their skills, abilities and aspirations. Across many services we are looking to engage individuals with active communities through targeted projects focused on preventing diabetes, increasing physical activity, reducing social isolation via befriending, and wellbeing services that tackle non-clinical issues impacting on an individual's health. These all strongly reflect the preventative nature of the three Health and Wellbeing Strategy priorities.

In Surrey East and Surrey Downs LJCGs, a specific initiative that demonstrates how the LJCG is using the BCF to embed integrated approaches to the prevention agenda is the Growing Health Together project. This project supports the adoption of preventative and proactive care in local communities by linking GPs and other healthcare professionals with their local communities to create sustainable, healthy communities. The BCF also supports links between acute services and community services in Surrey East and Surrey Downs by the funding of an acute-based Occupational Therapist linking with Social Care, Community and acute OT Teams.

In Farnham the BCF funds posts such as a Reablement Team Leader, a Reablement Support worker and a Rehab Support worker. All these roles are supporting the Intermediate Care teams and facilitating the further integration between health and care. The focus is on admission avoidance and supporting discharge. Also, within the Farnham area, the tackling loneliness project has brought together health, social care and the voluntary sector to support specific groups of people with isolation. This has included working with the Town Council as well as the PCN.

Support for carers that enables maintenance of their own health and wellbeing is funded largely by the BCF. There are Surrey-wide contracts that report to each of the LJCGs to ensure appropriate tailoring for each place. This year the specifications for these services have been significantly refreshed ahead of an open procurement exercise for a new suite of contracts commencing in April 2022.

Working in partnership with Guildford and Waverley place-based partnership and Procare (on behalf of the four PCNs), a more joined-up approach has been reached with social prescribing, in line with

the NHS's directive to work in partnership with Local Authorities. There is now one specification, joint contract monitoring and shared outcomes covering BCF and PCN.

Within Surrey Heath and Farnham, there is a strong focus on giving people and communities more control and a greater voice in helping to deliver the priorities of the BCF. Housing, DFG and associated services continue to optimise their impact on the three BCF priority areas. This includes a recurrent commitment to jointly fund a homelessness case worker in Surrey Heath.

Looking forward, whilst not currently directly funded by the BCF, new approaches such as those being developed through use of the money awarded to Surrey through the successful Changing Futures bid are also being discussed by local joint commissioning groups. This will help us to better understand potential alignment with future BCF planning. The Changing Futures Programme is a three-year stream of funding secured by Surrey partners to improve how the system functions to better support those experiencing multiple disadvantage in Surrey. There is a clear link with both the local BCF priorities, and the multiple partners involved in the Health and Wellbeing Board and Strategy.

5. Supporting Discharge (national condition four)

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.

BCF funding actively supports safe, timely and effective discharge from hospital with a range of provision supporting individuals across all discharge pathways. 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. Social prescribing services are working with people to develop tailored plans and connect them to local groups and support services.

To support successful discharge, across the county there is improved access to urgent and planned primary care, through extended hours and e-consultation. Supported discharge from acute hospital setting is taking place using in-reach, discharge to assess and step-up/down services. In addition, countywide stroke support services for patients on 'supported discharge' continue to be commissioned to prevent readmission. Post-acute patients are referred to Stroke Support Workers before discharge and arrangements are made for follow-up when the person is at home.

Within this year's Better Care Fund £1,000,000 is allocated to staffing for D2A. In Surrey, our Discharge to Recover and Assess (D2A) scheme is a key way in which we will be trying to support people to go to their usual place of residence from hospital and to be ready for discharge as soon as possible in the same day. We want our Discharge to Recover and Assess scheme to enable individuals to receive care and support out of hospital before being assessed for long-term needs. This means that they can be assessed over a period of time and at the right time and in the right place. This increases opportunities for independence. The D2A scheme in Surrey is ensuring people leave hospital with a package of care in their own home rather than entering more formalised care arrangements such as residential and nursing care.

Learning from the D2A approach has also highlighted the risks of social care placements being made at pace without the necessary infrastructure in place locally and County-wide to make these placements in a considered and appropriate manner. We intend to use this learning locally by enhancing community wrap-around support to help people settle back in their homes following discharge and by continuing to build on our offer of patient transport, home from hospital, home adaptations and short-term support.

A key tenet of D2A is effective integrated working between partners in health and social care in Surrey. We are strengthening this by developing plans to grow our therapeutic and wrap - around support offer to ensure that people coming out of hospital are supported to recover and rehabilitate without having to rely on long-term support where possible.

Across all LJCGs there is a focus on enabling people to return home soon from hospital and remain well at home as set out in our county-wide ambitions for the BCF.

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

- The Handypersons Service to help patients remain safe at home preventing admission and supporting patients post-discharge.
- BCF funded Community Equipment Services will continue to enable quicker discharge from hospital so that people can live comfortably at home. We have increased the budget and resources into this area.
- Home from hospital schemes to support people with low-level needs to return safely to home from hospital such as The British Red Cross Independent Living Service and other local Safe and Settle Schemes. These aim to prevent readmissions and support people to settle back at home with effective reablement.
- Investment in Adult social care and CHC assessment capacity.
- Investment in staff roles that support discharge and prevent admission. In Guildford and Waverly, the BCF supports a jointly-funded administrative post to assist with the discharge hub and funds a GP in A&E to help prevent admissions. In Surrey Heath there has been investment in Increased Physiotherapy capacity to support discharges.
- Hoppa Bus – a dedicated service taking residents to Royal Surrey County Hospital and all other health facilities between Haslemere and Guildford.
- BCF supports additional home care resource to enable early and safe discharge to individual's homes with a reablement approach to increase independence. Further information is set out below.
- BCF funding is supporting Technology Enabled Care Services which are currently in phase 2 of a pilot.
- Within East Surrey, the need for further development of services to support timely discharge from hospital and reduce length of stay is recognised. Partners are therefore developing plans for an Integrated Discharge Home to Recover Service which will support people to return home with short-term care and multi-disciplinary wrap around support. As part of this approach, new integrated approaches to recruitment are being explored and we will use the learning to develop a future sustainable model. This work will report into the A and E Delivery Board as well as the East Surrey Health and Care Partnership Board.

Surrey's Better Care Fund continues to invest in the Reablement workforce and Integrated Intermediate Care Teams to best support timely discharge from hospital. This is a key element in enabling people to live in their own homes, and in assisting people in the transition from hospital to home following treatment.

Over the past year, we have been developing a new model of reablement in Surrey based on a therapy-led approach, which is an investment in Occupational Therapists. The transformation of reablement was initiated by the Practice Improvement Programme and is continuing under a new programme, Care Pathways.

This has begun to improve client outcomes and promote a strengths-based approach. The aim is to reduce the need for ongoing services and create an improved quality of life for clients and greater independence. SCC's focus on proactive and preventative interventions includes active engagement with technology-enabled care.

As part of Surrey's transformation project and implementation of a therapy-led reablement model, SCC is working collaboratively with home-based care providers to deliver a short-term period of

strength-based, reablement-focused care to residents. The SCC Reablement Service is a key part of this system. Individuals receive personalised skills-gains programmes within their own homes for up to a maximum of six weeks. This helps prevent hospital admissions and supports hospital discharge.

The purpose of the Reablement Transformation Project is to develop an in-house reablement service to support people within the community by:

- Reviewing the reablement organisational structure, developing and embedding a therapy-led offer, and increasing capacity through recruitment.
- Developing the workforce by delivering a strengths-based practice approach and upskilling staff to further promote independence.
- Digital transformation within the in-house Reablement Service, including staff management system and care management.
- Collaborative Reablement Service: in-house Reablement Service and domiciliary services working together to increase the reablement offer.
- Work with the Technology Enabled Care project to roll-out reablement initiatives
- Develop an integrated and specialist offer of reablement for Learning Disabilities and Autism and Mental Health.

Surrey County Council (SCC) recognises that to be healthy and well, with dignity and independence and to remain in your own home can prove more challenging for some than others but wants this to be the aspiration for all residents living in Surrey.

6. Disabled Facilities Grant (DFG) and Wider Services

In Surrey, DFG funding is pooled and cascaded to the eleven District and Borough Councils in line with national guidance, with discussions in each locality to agree the use of the funds

The DFG is at the heart of the housing assistance services offered by local Councils and is the core mechanism by which most authorities are able to improve the housing conditions and promote independence of people with disabilities or care needs. This includes adaptations such as level access showers to allow safer and more independent bathing, stair lifts to facilitate safe access around the home and ramps to provide easier access in and out of properties. These simple adaptations can make an enormous difference to the lives of those with disabilities or care needs, as well as their families.

The strategic approach to use of the DFG is coordinated via the Surrey Equipment and Adaptations Steering Group. It includes representatives from the eleven Districts and Boroughs, as well as Surrey County Council and Clinical Commissioning Groups, and meets quarterly. The Group is designed to act as a forum for agencies involved with equipment and adaptations in Surrey to discuss and plan opportunities for increased efficiencies and effectiveness of the Home Improvement Agencies and Handyperson Services, including their links to Health and Social Care.

The membership of the Steering Group promotes closer links and more effective partnership working with social care teams. This creates a greater scope for mutual understanding of service user needs and how they can be met.

Further strategic partnership development has taken place between the County and District Councils following a review of the local Handyperson Services provided within each locality. The review has welcomed input from the local providers to understand:

- Criteria for access to service
- Relationship with the DFG
- Outcomes captured and recorded

The review has been a success with thorough engagement from the Surrey Equipment and Adaptations Steering Group to drive continuous improvement and share best practice across the county. It has been evidenced that this service is supported financially both by the local providers' investment and the DFG and the BCF. The County Council (as a commissioner of the service for the BCF provision) has drafted a new service specification to be agreed at the local BCF forums to provide clear expectations for delivery, eligible individuals, and primary outcomes to focus on and measure success.

Another example of the integration between Housing Adaptations Services and Social Care is the Surrey-wide agreement currently in place on the Community Equipment Service (CES). The CES provides clients with items of equipment or simple adaptations such as ramps and handrails and is free to the client. The CES is a jointly commissioned service between Surrey County Council and Surrey Health Partners. It provides access to a catalogue of equipment for over 1000 clinicians from the partners' operational teams in the community, community hospitals and acute hospitals.

The primary purposes of the CES is to:

- Promote independence, reablement and meet long-term need.
- Delay increases to care needs
- Avoid hospital admissions and admission to care establishments
- Facilitate hospital discharges

- Support with palliative care

Use of the DFG at place is also discussed at LJCGs. Examples of this approach include:

- Quarterly meetings with Districts and Boroughs to discuss DFG.
- Occupational Therapists are involved with ensuring provision is reasonable and appropriate.
- Boroughs work closely together on their approach to ensure consistency and best use of resources.
- Local prioritisation of greater partnership working between health, care and housing to ensure all opportunities are realised to support people in their own homes. This includes (in some areas) senior managers in the Borough Council who are operationally responsible for housing services and the DFG, being core members of the LJCG.

7. Equality and Health Inequalities

System response to addressing Health Inequalities:

In Surrey, as nationally, Covid-19 has further exposed some of the health and wider inequalities that persist in our populations.

In 2020, a COVID Community Impact Assessment (CIA) was carried out in Surrey. This found that it is likely that the pandemic has had a disproportionately negative impact on certain groups of residents. It identified 10 vulnerable groups with pre-existing vulnerabilities at a greater risk of mortality from Covid-19 and a series of 'Rapid Needs Assessments' were then carried out to understand the impact the pandemic has had on each of these groups. The 10 vulnerable groups identified were: people with long-term physical health conditions, Care Home residents & families, Black, Asian and Minority Groups, people with mental health conditions, people experiencing domestic abuse, children with Special Education Needs and Disabilities, people with drug or alcohol problems, the Gypsy Roma Traveller Community, young people out of work and people experiencing homelessness[1]. These have been adopted as Priority Populations of Identity in the refreshed Health and Wellbeing Strategy. Going forward, we will look at how local programmes are targeting activity to ensure a focus on reducing health inequalities within one or more of these groups.

Some of the impacts identified within the CIA that particularly relate to BCF-funded programmes include:

- The health impacts have been felt the most in areas with higher numbers of over 80s and care homes.
- Residents living in residential care homes have felt more isolated.
- People from Black, Asian and Minority Ethnic (BAME) communities have struggled to access support.
- Lockdown has impacted many residents' mental health.
- The pandemic had significant impacts on those already using mental health services.

Our local Integrated Care Systems 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. In Surrey Heartlands, the Equality and Health Inequality Workstream has combined with the 'Turning the Tide' Board to consider both the outcome of the Health and Wellbeing Board's Community Impact Assessments and the issue of equality and health inequalities for our citizens and patients but also the workforce that supports this care. The role of the new Equality and Health Inequalities Board is to respond to the immediate disproportionate effects of Covid-19 on our populations that are alluded to in the RNAs (e.g. Black, Asian and Minority Ethnic communities) but also to focus on our response to the NHS Operational Planning Guidance which outlines five priority areas for tackling health inequalities.

Following on from this, an Insight and Analytic Task and Finish Group has developed an internal Health Inequalities Dashboard, looking at 51 indicators which are soon to be expanded upon to consider elements related to waiting times, diagnostics, and referral rates for BAME, Sex, Deprivation, LD and SMI. The Task and Finish Group has focused on ensuring that there is equity of access within the system across elective and non-elective care. It has reviewed the data that has been gathered and then focused its work on potential areas of concern. Where relevant this will consider and include the

[1] Impact of Covid-19 on our Communities – Surrey-i (surreyi.gov.uk)

data made available on BCF metrics that includes ethnicity and age information to support analysis and response across the system.

Key to this work on health inequalities is our need for continued and greater engagement with communities and the third sector which is represented in the refreshed Health and Wellbeing Strategy.

In the context of Frimley Health and Care Integrated Care System, 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, within areas such as the Frimley ICS, population health management approaches, data segmentation and risk stratification have 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.

This also involves work with Voluntary and Local Government partners to reach minority communities whose access has been most affected by Covid and/or the shift towards digital contact and to detail plans to mitigate the risk of digital exclusion. Frimley ICS will be strengthening leadership in this area with the appointment of a system lead for equality, diversity and inclusion who will sit on the ICS Partnership Board.

The rationale for the refresh of Surrey's Health and Wellbeing Strategy – as set out in the Governance section – is to address the impact of COVID on health inequalities. It has been agreed that the existing overarching ambition that 'No-one is left behind' be more obviously emphasised and linked specifically to a reduction in health inequalities – 'Reducing health inequalities so no-one is left behind'. This incorporates the action outlined above and ensures it links with the work happening within the wider determinants of health to also reduce health inequalities.

The Population Intervention Triangle (PHE, 2017) was adopted to guide strategy implementation, and this has subsequently been adapted to reflect Surrey's aspirations for community-led interventions that can reduce health inequalities. An updated list of priority populations for the strategy has been developed based on the 2020 CIA. The refreshed strategy also sets out an enhanced collaborative effort to work creatively with those communities in the geographic areas of deprivation with the poorest health outcomes and establishes a system-wide adoption of a Health in All Policies approach.

How the BCF tackles health inequalities in Surrey:

When developing BCF plans, LJCGs 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.

Specific examples of how the BCF in Surrey contributes to programmes to reduce health inequalities and promote equality include:

- Investment to support Surrey's All Age Autism Strategy. Surrey's All-Age Autism Strategy 2021-2026 aims to improve the lives of the estimated 12,300 autistic people living in Surrey, by breaking down barriers and inequalities that autistic children, young people and adults face in education, health, social care, work and communities.
- In Farnham, The Tackling Loneliness project has brought together health, social care and the voluntary sector to support targeted groups of people who were at the highest risk of loneliness and isolation. Projects funded include: Farnham Neighbours Network, The Farnham Craft Café, Carer's Coffee Break, Men in Sheds.
- Sight for Surrey Friendship Group Grant - the grant supports Sensory Services by Sight for Surrey's specialist worker and team via the Friendship Group to identify people with combined sight and hearing loss so that they receive appropriate support to be able to communicate. This is vital if they are to maintain physical and mental health, and thus remain independent.
- Grant to Outline, a registered charity supporting people in Surrey who are Lesbian, Gay, Bisexual and Trans (LGB&T) or are questioning their sexuality or gender identity. Current service provision of a helpline and support groups delivering services for local people by local people.
- Free access to digital services for isolated individuals with provision of free equipment and data.
- In September, East Surrey LJCG approved BCF funding to pilot an Autistic Friendly Communities initiative, which is expected to reduce the demand for health and care services by enabling people to enjoy a healthy and active life within their communities. It will support the development of individual' social networks, which have a significant impact on health and prevent unnecessary hospital admissions. Social networks have been shown to be as powerful predictors of mortality as common lifestyle and clinical risks.
- Developing local communities in areas of deprivation via the Growing Health Together Programme across East Surrey.
- In Surrey Heath, funding from the BCF enables targeted support to reduce inequalities, including for those with protected characteristics under the Equality Act, as part of the Whole System Obesity project. This enables people to stay well by 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. There is known variation and inequalities across the community and the approach is tailored to local needs. including the needs of those people with protected characteristics
- Reablement services – Surrey County Council is endeavouring to develop an 'access to all' reablement model. This would include clients with mental health conditions, learning disabilities and autism. We are working towards this by expanding our specialist knowledge and broadening available capacity by working collaboratively with providers.
- Funding for Social Prescribing Services that are targeted to address health inequalities and the wider determinants of health by supporting people with their non-clinical needs and by connecting them to sources of help and support within local communities.

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