HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s):

Southwark

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

Partnership Southwark members including South East London Integrated Care Board, Southwark Council (Public Health, Children and Adult Services, Housing), VCSE representatives, South London and Maudsley NHS FT, King's College Hospital NHS FT, Guys and St Thomas's NHS FT

How have you gone about involving these stakeholders?

Engagement via Partnership Southwark and Health and Wellbeing Board discussions on strategy, and underpinning engagement on Partnership Southwark strategies and the SELICB Forward View

Governance

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

The BCF is agreed between the council and the ICB prior to approval by the Health and Wellbeing Board. After a draft has been agreed through the BCF Planning Group in consultation with stakeholders it is formally agreed through each organisation's respective governance requirements, then presented to the Health and Wellbeing Board. It is also subject to approval through a national BCF assurance process before being formally agreed.

The pooled budget arrangements are governed by a Section 75 agreement between the council and the ICB which sets out shared responsibilities to implement the planned spending as agreed. This Section 75 agreement is formally signed after the national approval letter. The BCF is subject to quarterly and year end reporting to NHSE, reviewed internally and agreed by the council and ICB before submission. Each scheme in the BCF is assigned a lead organisation responsible for the expenditure on that budget which is managed within the governance arrangements of the lead organisation.

In Southwark the BCF Planning Group has been set up to agree plans and oversee the high-level monitoring of the BCF on behalf of the Health and Wellbeing Board and to agree any changes to the use of funding. This group includes the Director of Adult Social Care, the council's Director of Commissioning for Children and Adults and the ICB's Chief Operating Officer for Southwark on behalf of the Place Executive Lead as well as Finance leads.

The BCF Planning Group is a sub-group of the Joint Commissioning Oversight Group which oversees health, public health, adults and children's social care joint commissioning arrangements.

Governance Arrangements for the Southwark BCF (Schematic)

* Partnership Southwark helps shape the future strategic direction of the BCF as part of the delegation of ICB governance to local care partnerships. It also oversees the Live Well, Age Well and Care Well programmes to which the BCF is aligned.

There are also overlaps with other programme governance arrangements in SEL ICB such as the Urgent and Emergency Care Board that oversees the new ICS discharge improvement plan and winter planning.

1. Executive Summary

This should include:

• Priorities for 2023-25

• Key changes since previous BCF plan.

Background to the BCF

The Better Care Fund (BCF) is a pooled budget held between the council and the NHS that funds a range of core community based health and adult social care services. It was originally formed in 2015/16 by consolidating a range of existing funding streams for health and social care. It is a mandatory pooled budget to which the NHS and Council are required to make stipulated minimum contributions, with minimum ringfenced amounts to be spent on social care and health. The value of the BCF for 2023/24 is £54.2m, including £2.5m additional funding above the minimum required level. The current plan also covers 2024/25 for which the expected budget is £58.8m. The delivery of the pooled budget is underpinned by the associated Better Care Fund plan which sets out how an integrated approach to the delivery of services will secure improved outcomes in line with local and national priorities.

Priorities for 2023/25

The local priorities of the Southwark BCF align strongly to the national statement of the BCF vision and objectives, which are set out as conditions in the planning guidance, to:

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

This will help deliver the twin goals of **preventing avoidable admissions to hospitals and care homes** and **supporting safe, timely and effective transfers of care from hospital**.

In addition, achieving these objectives will support the delivery of population health and wellbeing outcomes and help tackle health inequalities as set out in our partnership plans by targeting resources at those most in need of support.

This plan sets out how these objectives will be achieved through the BCF in Southwark.

Local priorities and plans aligned with the BCF

The BCF plan is a key enabler for the delivery of a number of local partnership plans that are closely related, including:

- **The Southwark Health and Wellbeing strategy** – including priorities relating to early identification to stay well and the integration of health and social care
- **The draft Partnership Southwark Health and Care Plan** – including priorities relating to Age Well and Care Well, mental health, integration, collaborative working and neighbourhood working
- **The ICB Joint Forward View –** including priorities relating to strategic system wide collaboration
- **The ICS Integration Strategy –** priorities relating promoting health and well-being, and support for people with long term conditions
- **The ICB Operational Plan –** including its focus on recovery of NHS urgent and emergency services

Key focus areas for 2023/24

As set out in this plan there are a number of areas for development in 2023/24 including:

- Delivery of the South East London ICS Improvement Plan for physical and mental health transfers of care including the development of internal flow hubs and home first/ discharge to assess, reducing delayed transfers of care and avoidable long lengths of stay. This will both improve outcomes for patients and increase acute capacity and support recovery of planned and urgent care services
- Securing data improvements to support capacity and demand planning
- Additional Discharge Funding arrangements to be fully incorporated into BCF and deliver maximum impact on delays
- Development of step down options including facilities to reduce delayed transfers for pathway 2 and 3
- Development of a refreshed Market Position Statement in 2023, which for the first time will be joint, relating to care and related health services

Broader system priorities influencing our BCF approach include

- Continuing to support system recovery from the pandemic
- Strengthening the alignment of resources and shared understanding of collective budgets across Partnership Southwark - including a focus on developing collaborative approaches to mental health services in 23/24
- Support further development of the neighbourhood model to promote integrated multi-disciplinary working focussed on outcomes and community needs
- Strengthen whole system resilience in the face of anticipated intensive pressures, including pressures arising from demand in numbers and complexity of need (in particular due to possible flu, covid and cost of living pressures), industrial action, cost pressures, workforce recruitment and retention and funding issues.
- Ensuring a good quality and sustainable provider market that can meet demand, particularly in care homes, home care and community health therapy services
- Supporting the ongoing bedding in of the South East London Integrated Care System, including the Integrated Care Board Southwark borough team and the Partnership Southwark arrangements, which were formally established in July 2022.
- Supporting a reduction in health inequalities in line with the refreshed Health and Wellbeing Strategy, and aligned to the Southwark Health and Care Plan (due to be signed off in July 2023)
- Ensuring all services in Southwark contribute to the goal of reducing environmental impact in line with the Partnership Southwark sustainability policy statement as set out on page 33.

Key Changes since previous BCF Plan

Increased national focus on discharge from hospital

There has been a nationally driven increase in the focus of the BCF on tackling delayed transfers of care from hospital. This is reflected by the incorporation of the Additional Discharge Fund into the BCF plan, and a focus on contributing to the delivery plan for recovering urgent and emergency care services, reflecting the ministerial priority to tackle

immediate pressures in delayed discharges. There has been a significant level of system and place level improvement work on discharge as set out in more detail in the section on national condition 3.

At a local level Southwark has responded to this agenda but admission avoidance remains a key focus of the BCF plan that is given equal weight to discharge.

Additional Discharge Fund

The Additional Discharge Fund (previously called the Adult Social Care Discharge Fund) was first incorporated into the BCF in December 2022 as a variation to the core BCF plan. It provided £2.56m non-recurrent funding for a range of Q4 initiatives that directly supported timely and effective discharge, with year-end reporting highlighting a significant impact supporting 817 transfers of care. This has now been made a core part of the BCF allowing for a number of the schemes to roll forward including council led schemes relating to reablement, homecare, double-handed care, extra care and sheltered accommodation, residential and nursing care, recruitment and retention, VCS, step down flats, brokerage and the transfers of care assessment team. The ICB element includes a strong focus on mental health discharge, in particular the provision of supported housing, and on the support required to co-ordinate these discharges. It is also focussed on supporting discharges from acute settings via the provision of increased therapy support where required to enable discharge and the provision of a social worker in ED who can work on pre-admission discharge planning. Additional resources are also allocated to provide a budget for flexible commissioning of services required to assist complex discharges of people on pathways 2 and 3**.** A scheme to support discharges of homeless people has also been funded.

New schemes for 23/24, for which the full year budget increases to £3.9m, include the development plans for intermediate care step down beds provision initiative outlined below and include investments in residential care to increase capacity. It is anticipated that on the basis of national funding growth figures the discharge fund will increase to £7.1m in 2024/25. Plans described for 2024/25 are provisional and will be reviewed later in Q4 23/24.

Development of more specialist bed based intermediate care services

Southwark has one of the highest rates of discharge to normal place of residence in London, reflecting a strong home first approach supported by a range of intensive community based health and care services funded by the BCF. However, an identified capacity gap in our intermediate care offer relates to people who cannot be discharged home as they require specialist bed based rehabilitation services. These patients frequently experience delayed transfers of care, some with a high number of delayed days in hospital after being clinically ready for discharge, due to waiting for a place to be free in a suitable bed based service.

The Council has transferred the running of four older people residential care homes to a new provider who will be a strategic partner to repurpose some of the rooms across the four homes to provide nursing care so that people can ‘age in place’. As part of the redesign of provision, a floor that has been vacant in the lead up to the transfer is being furnished to provide D2A or reablement for up to 17 people from the autumn of 2023. This expansion of provision will support complex pathway 2 step down from acute settings, particularly with multi-disciplinary work within the community to support safe and sustainable transfers of care where people can live safely and successfully in community settings, whether at home (private residential or extra care) or in a regulated setting such as a care home or supported living.

In addition, the ICB are in system wide discussions around options for developing health funded capacity for complex pathway 2 and 3 discharges from additional discharge funding.

Key Budget Changes 2022/23 to 2023/24

Although the BCF predominantly consists of schemes and budgets that have rolled forward from previous years, there are new features to note for 2023/24 relating to the discharge funding, use of 5.66% uplift and some internal funding changes:

Council scheme budget changes:

- The incorporation of the Additional Discharge Fund (council grant element) totalling £2.502m into the BCF as a full year budget

- Net growth in Core BCF budget for council services funded from ICB contribution to BCF of £1.085m (5.66%)* to £20.255m
    - Annual uplifts for a range of council contracts and services (+ £1.152m)
    - New mobilisation funding for intermediate and nursing care contracts (+ £0.1m)

      Less:

    - Efficiency savings relating to voluntary sector hub model (- £0.167m)

- Repurposing of contingency and cost pressure budgets to residential and nursing care (£0.574m)

Note: there is no growth in council IBCF grant funded provision (£17.847m) or DFG (Disabled Facilities Grant) funded provision (£1.686m), although it has been indicated that DFG grant is expected to be increased mid-year.

ICB scheme budget changes:

- The incorporation of the Additional Discharge Fund (ICB devolved amount) totalling £1.599m into the BCF as a full year budget

- Net Growth of £415k (5.66%) in Core BCF budget for ICB services funded from the ICB minimum contribution to £7.841m:
    - Actual growth of £0.450m includes:
    - Annual uplift of NHS Community & Mental Health Contracts (+£0.277m)
    - New investment in GSTT community services (Occupational Therapy, Tissue Viability, Foot Health Therapies) (+£0.173m)

      Other changes (-£0.035m) include:

    - Funding for Speech & Language Therapist for GSTT Community Services (+£0.065m)
    - Consolidation of @home services by including Palliative Care @ Home service (+£0.326m)
    - Transfer of @home nursing budget from additional funding element to core BCF funding (+£0.109m)

      Less:

- Projected contract savings arising from re-procurement and change of provider to Integrated Community Equipment Service (-£0.15m)
- Self-management reductions reflecting 2023/24 contract values (-£0.054m)
- Service Development budget absorbed into ICB running cost budget (-£0.331m)

Changes to 2024/25

The assumed growth for Year 2 is summarised in the table, including a further 5.66% uplift in the ICB minimum contribution, and forecast draft increase in Additional Discharge Fund. These budgets will be subject to review prior to 2024/25 to take into account planning guidance, service evaluation and latest demand pressures.

Note: A full analysis of the BCF budgets is included in the Finance template

Other changes

Falls prevention – new metric and target

A new target has been introduced on admissions to hospital due to falls in over 65 year olds, which aligns with our long standing local priority around falls prevention. Although Southwark's rate on this indicator is close to the London average it is recognised that there is scope for improvement, and a target to reduce the headline rate by 5% has been agreed. A number of BCF services are focussed strongly on falls prevention including the GSTT community falls service, telecare, community equipment (ICES), reablement and rehabilitation, home care, care homes. Falls prevention strategy is part of the Age Well frailty workstream in the Partnership Southwark programme.

Note: Delayed transfers of care – new metric expected to be introduced during 2023/24

It is expected that a new target will be introduced mid-year reflecting patient delays, based on data provided by trusts which will incorporate the delay since "discharge ready date" into mainstream reporting. Plans for this target will be developed as part of mid-year reporting on the BCF.

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.

Joint priorities 2023-25

As set out in the Executive Summary (p.4) the key joint priorities reflected in the BCF relate to avoiding admissions to hospital and care homes and supporting safe and effective transfers of care from hospital, and a number of related areas of focus.

In broader terms as a partnership our priorities are summarised in the Joint Forward Plan which the BCF is an enabler for:

Approaches to joint/collaborative commissioning

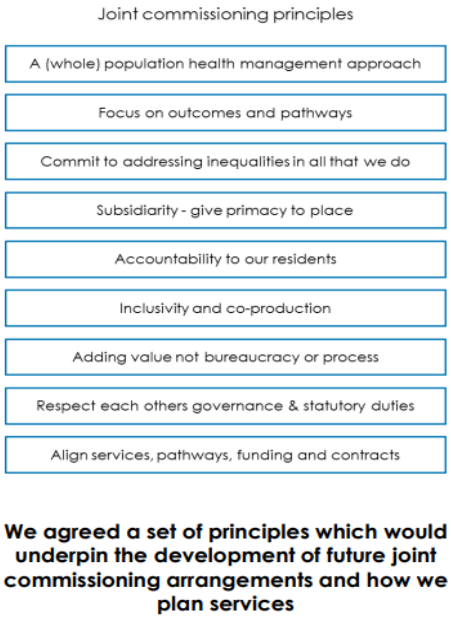
Southwark council and the ICB have a joint commissioning structure with teams responsible for delivering programmes to improve outcomes and address health inequalities for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded by the LA and ICB. The primary care commissioning team is part of the overall structure (led by a joint-funded post) to help ensure

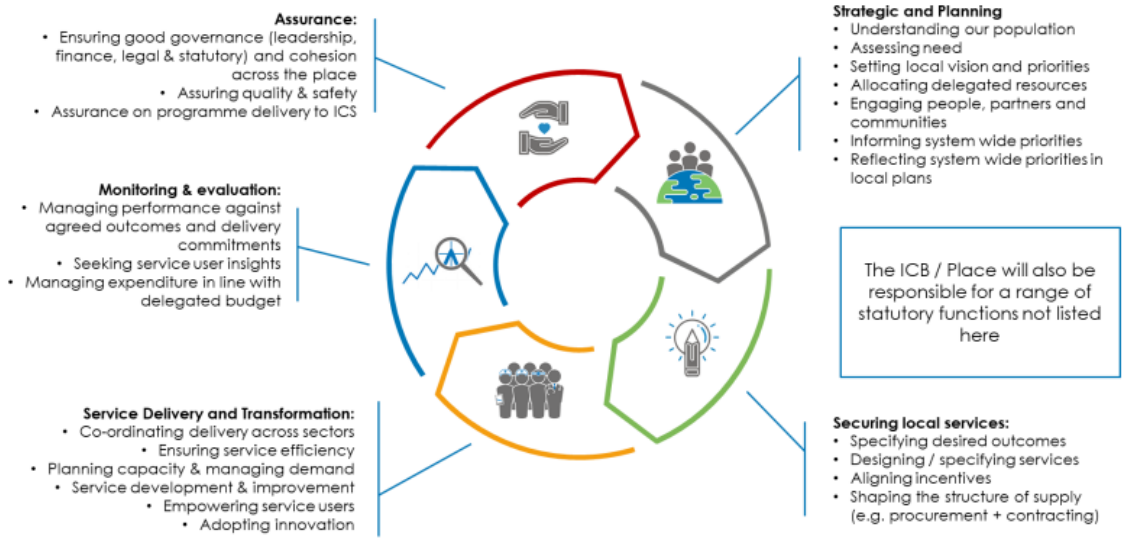
cohesion, although the team is not jointly funded. These arrangements are, of course, subject to the Hewitt Review recommendations.

The joint commissioning teams work closely with the Partnership Southwark programme team that leads integrated programmes under the Start Well, Live Well, Age Well and Care Well programmes which are focussed on facilitating improved joint working between providers.

There is a continued commitment to deepening the approach to integrated commissioning. . This includes building on our agreed key principles, our common framework for joint commissioning and planning progress against agreed “road map” milestones on an integration maturity matrix, and the development of integration demonstrator projects (see fig. 1).

Fig 1: Joint Commissioning Principles and common framework for joint commissioning





…..and discussed a common framework for joint commissioning, with the development of LCP functions underway to underpin the process and provide the necessary inputs

Key principles of the Bridges to Health and Wellbeing Approach

Partnership Southwark has previously agreed an approach to joint commissioning for improved population outcomes referred to as the Bridges to Health and Wellbeing model that was developed following extensive engagement. Whilst it was decided not to take a prescriptive approach to applying the methodology to all programmes, the model provides guiding principles that apply to all integrated workstreams:

1	**Organising the population into coherent groups –** grouping the population according to similar patterns of health and care need ('population segments') and associated relevant outcomes is a sound basis for developing a population based approach
2	**Agreeing outcomes for population groups** - the development of an agreed outcomes framework for each population group/ segment, like the approach used for the frailty, dementia and end of life segment, provides partners with a common focus
3	**Whole system approach to deliver the outcomes -** population health and wellbeing outcomes can only be fully achieved by all partners working together as a single Southwark system.
4	**The integrated service models need to be holistic and person focused** – health, care and universal services focussed on working together on the whole need of a person or population rather than service focused. Co-production of new service models with the public and the use of personalised outcomes for individuals in their multi-disciplinary plans is a key element of this.
5	**Prevention -** we need to shift resources to prevention if outcomes are to improve. This will mean sharing the costs, risks and rewards of investment in prevention opportunities we have identified.
6	**Providers and commissioners will need to work together in new ways -** with formal and informal alliances where necessary to deliver outcomes on which they are

	jointly accountable. This will include high levels of collaboration, trust, and data and intelligence sharing.
7	**Workstreams to be aligned to outcomes frameworks –** we need a structured approach to incorporating the delivery of improved outcomes into the way services are developed. This covers not just existing and proposed Partnership Southwark workstreams, but any relevant workstreams and "business as usual" services.
8	**Evidence based and driven by shared data –** The new integrated service models need to be based on in depth needs analysis using shared data on individuals and populations, mapping of existing services, gaps and opportunities, knowledge of best practice etc.
9	**Aligning resources and commissioning -** We need to consider all resources available for populations to improve outcomes and consider the best way of configuring them that is the best use of the "Southwark £".
10	**Commissioning for outcomes and contractual changes -** There will inevitably be a need over time for the approach to contractual specifications and payment mechanisms to shift to reflect the focus on outcomes – however the need for these to be evolutionary rather than revolutionary is recognised, with clear mechanisms in place to address system risks

How BCF funded services are supporting your approach to continued integration of health and social care.

A number of BCF funded services work closely with partners in a MDT approach, for example:

- The new Transfer of Care Service hospital discharge teams funded via the BCF work in close collaboration with acute and community health teams as part of the discharge process.
- Intermediate Care Southwark is fully funded by the BCF. It is an integrated service model incorporating council staff, council commissioned reablement provider and ICB commissioned intermediate care and community health services under a single management structure
- The Intensive Support Service (previously called Enhanced Intervention Service) is a BCF funded multi-disciplinary team supporting people with learning disabilities and challenging behaviour to remain in lower intensity community based placements. The team includes psychologists from SLAM, a social worker and a therapist from GSTT community team.

Changes to the services being commissioned through the BCF for 2023-25 are set out in the executive summary, and the following sections on National Condition 2 and 3

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.

The Southwark BCF will enable people to stay well, safe and independent at home for longer through the funding of person centred community based services that prevent the deterioration of health and wellbeing and help reduce avoidable admissions to hospital or care homes as part of personalised care plan. These are part of the wider neighbourhood MDT approach with primary care to preventing admissions for people identified as at risk of admission. Relevant BCF funded schemes include:

- Home care
- Step up reablement and intermediate care
- Urgent Community Response (with increased direct self-referral in 23/24)
- Support to carers
- Telecare and community equipment
- VCS funding – e.g. older people's hub, social prescribing
- Falls service
- Self-management funding for people with long term conditions
- Flexi care/ Extra care
- Mental health and learning disability personal budgets
- Mental health reablement
- Lower limb wound care/ Tissue Viability
- Disabled Facilities Grant

These services will support the wider system in delivering the Fuller report recommendations. The Southwark Fuller Delivery Group has objectives for 2022/23:

- To enable all Primary Care Networks (PCNs) to evolve into integrated neighbourhood teams, supporting better continuity, preventive healthcare and access
- To ensure proactive healthcare and support, targeted at people of all ages living with frailty, multiple long-term conditions and/or complex needs, to help them stay independent and healthy for as long as possible at home, in the place they call home or in their local community
- To improve the management and experiences of people with LTCs.

- To develop strategies to develop high intensity user services and address UEC demand management.
- To ensure patients have access on the day for urgent problems.

This will be in the context of improved access to primary care services in line with primary care recovery plan, which is identified as a key factor in avoidable admissions.

In addition, the objective is supported by our broader prevention strategy such as the focus on hypertension as part of our Vital 5 screening initiative.

Link to discharge strategy: it should be noted that in order to ensure a rounded view on patient flow the system discharge improvement plan set out on page 18 includes a key objective around prevention of admissions, including re-admissions.

National Condition 2 (cont)

Demand and Capacity

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

See commentary on demand and capacity planning for national condition 3 on page **21.**

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.

BCF funded services play a vital role in enabling people to stay well, safe and independent at home for longer. Examples of how these impacting on the key metrics include.

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions:

- BCF funded community health services including Urgent Community Response enabling referrals for intensive support to prevent admission and the @home service as an alternative to admission, including palliative care at home
- Self-management courses for people with long term conditions, including Self Management UK and Walking Away from Diabetes
- Services such as home care play a key role in supporting the health and wellbeing of people with long term conditions and escalating concerns about health conditions at an early stage, and BCF funded social care services will play a key role in the emerging neighbourhood model with integrated multi-disciplinary working focussing on admissions avoidance objectives.

Emergency hospital admissions following a fall for people over the age of 65

- The BCF provides £857k funding for the Southwark Community Rehab and Falls service. This service specialises in preventing falls, caring for people who have had a fall or fracture or if there are concerns about the risk of falling. The service includes a falls clinic, strength and balance classes and information advice and support to patients and carers.
- Addressing the risk of falls is a key theme running through a range of BCF funded services. Falls risk assessments underpin the provision of reablement and rehab, community equipment, minor adaptations and major adaptations through the Disabled Facilities Grant.
- The telecare services provides specific services enabling falls to be responded to, including specialist staff and equipment for lifting people after a fall rather than calling an ambulance.

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.

- The BCF provides funding for an extensive range of personalised home based services that enable people to live independently and safely at home in the community for as long as possible, avoiding or delaying the need for permanent admissions to care homes. This is a key objective of our home care, extra care,

reablement, intermediate care, rehab, housing adaptations, equipment, voluntary sector hub and carers support services.

- Discharge related services are focused on a home first approach rather than transfer to a care home as set out in this plan
- A number of these areas have been strengthened through the use of the additional discharge fund, including schemes to fund step down flats and strengthen supported housing options in mental health

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.

Additional Discharge Fund: The Additional Discharge Fund has provided significant investment for this objective as set on page 6.

South East London Integrated Care System – in depth review of discharge and 2023-2025 improvement plan for transfers of care

The key development in terms of planning for improving transfers of care relates to the development of this ICS plan which Southwark intends to actively deliver with partners.

Building on the outputs of a number of system and place level discharge related workstreams, in March 2023 the ICS held a Discharge Summit to enable system leaders to come together and discuss how to improve both timeliness and quality of discharge from our acute and mental health providers. A wealth of suggestions came from that discussion and, as a system, it was agreed to develop a SEL Discharge Plan that all partners in the ICS can commit to delivering. This System Plan has been developed in conjunction with the Discharge Solutions Improvement Group (DSIG) and the SEL MH Discharge Group (sub-group of DSIG) and aims to define our mission, objectives and the measures by which we will deliver improvement over the next two years (2023-2025), aligning to BCF improvement plans.

A mission statement for the plan was agreed as follows:

"When medically and therapeutically ready, our residents will receive good, safe and timely transfer of care from hospital to home. Irrespective of whether they have mental or physical health needs, they will feel that the care on offer is to help them recover as quickly as possible with no hospital stay longer than needed".

High level objectives were agreed and detailed action plans for each objective is set out in full overleaf.

Discharge Improvement Plan Objective 1: We will work to a **common framework** to deliver transfer of care standards

South East London Integrated Care System

Standards: a) Complimentary model for TOC Hubs with agreed language and definitions; b) Home first wherever possible (within a D2A process); c) Standardised discharge policies where appropriate across acute providers (physical and mental health)

	Actions	Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Implement 10 immediate actions and 7 recommendations from SEL TOC review with initial focus on priorities 1-3: 1) **SEL discharge plan owned by all system partners with shared ambition** 2) **SEL operating model for TOC/Flow hubs (including agreed common language and definitions)** 3) **Significantly increased focus on P0 with dedicated P0 co-ordinators in hubs** 4) Regular discharge audit programme across SEL 5) Review of data captured to align and expand current data and review targets to improve performance 6) Strategic review of most efficient TOC/Flow hub model for SEL 7) Hub access to Social Care management IT systems	TOC Review Delivery Tracker Oversight and collection and monitoring of P0 data including complexity and delay reasons Non CTR by Pathway, number of patients discharged, TOC LoS by pathway and borough	SEL TOC Review	1) DSIG 2) Sub-group: TOC leads (SEL co-ordinated) 3) Acute DOOs	Q1 23/24 Q3 23/24 Q3 23/24	DSIG DSIG AFIG
B)	Commission demand and capacity planning and associated reviews for key areas (e.g. intermediate care, weekend working/extended hours and mental health)	Base-line audit HICM maturity assessment	TOC – HICM – Change 5	SEL commissioned	Q2 23/24	DSIG & BCF
C)	Embed the Mental Health Discharge Framework and improve delivery against baseline assessment	Base-line audit	100 day MH challenge	SEL MH Discharge Group	Q4 23/24	DSIG

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Discharge Improvement Plan Objective 2: We will secure pathways that are **safe, personalised and promote independence and recovery**

South East London Integrated Care System

Standards: Clear processes for transferring patient care to give all patients opportunity to recover in the community: a) before an assessment for their reablement and long-term care needs takes place (physical health); b) through shared lives and stepdown accommodation options with psychosocial support (mental health). Where recovery is not an option c) to maximise quality of life in final months, weeks or days of a person's life.

	Actions	Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Improve, promote and enable through the transfer of care model: • Greater access to intermediate care and reablement services for our patients • Providing these services at the right time to maximise the patient's recovery. Achieving successful outcome for the patient around wellbeing and living as independently as they can with no ongoing or minimum levels of on-going support. Place-based funding and investment plans aligned to this action to evidence where local investment will support delivery	Reablement ADASS monthly return (SALT) AND BCF 91-day Intermediate Care Metrics SEL Discharge Dashboard		Place-based	23/24	DSIG
B)	Implement evidence based best practice, including discharge to assess and home first models as our embedded approach to transfer of care e.g. SEL Policy and action cards on how to transfer care for out of borough patients without delay	ASC outcome framework BCF indicator dashboard	Discharge guidance TOC – HICM Bromley policy & action cards	Place-based improvement spread across SEL	23/24	DSIG & PELS
C)	Develop the range of supported housing and shared lives initiatives for fragile mental health patients stepping down into the community with psychosocial support enabling residents to regain their skills to cope with activity around daily living (independence).	Place based BCF metrics	Review PSSRU Outcome measure	Place based and MH Discharge Group/BCF	23/24	DSIG and PELS
D)	Early planning for patients requiring end of life services that supports the aims of dying well. Training of all staff working in discharge to proactively identify patients who are approaching the end-of-life care phase to support earlier access to palliative care services. Making advanced care planning and use of universal care plan the norm.	Audit of use of universal care plan Reduction in number of people dying in hospital EoL national data set	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EOL steering group

Discharge Improvement Plan Objective 3: We will **meet complex patient needs**

South East London Integrated Care System

Standards: SEL has clear processes for transferring patient care into the community to: a) continue treatment/ recovery that enables longer term planning; b) meets planned and unplanned health needs and c) enables where possible a patient to die in the most suitable setting (of their choice)

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Developing safe and appropriate pathway for patients with complex clinical or discharge challenges: • dementia & delirium pathways • transfer of care to bed-based services for patients with complex needs Recognising that these will be developed at SEL level where possible for local adoption based on population need	Readmission rates	Good practice evidence base to be gathered	D&D sub-group Place-based leads linking with CH group	Q3 Q3	DSIG
B)	Develop a SEL approach to patient deterioration escalation and pre-crisis planning (mental and physical health)	Readmission rates		Identified clinical leads (tbc)	Q3	DSIG
C)	For patients with complex needs reaching end of life engaging the range of services (e.g. health and care support, hospice care, accommodation and equipment) to enable a dignified and comfortable death wherever possible	Audit of delivery of care against universal care plan	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EoL Steering Group
D)	Maximising the opportunities to adopt pooled funding and risk/gain share approaches to reduce TOC delays	TOC delays		Sub group	Q2	DSIG
E)	Place-based funding and investment plans aligned to the SEL discharge plan to evidence where local investment will support delivery of SEL objectives	Local discharge improvement plans and delivery updates		Place-based	Q2	DSIG

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Discharge Improvement Plan Objective 4: We will focus on **avoiding unnecessary admissions**

South East London Integrated Care System

Standard: To ensure people are only admitted to hospital when their care can no longer be managed at home. People requiring access to urgent and emergency care are not admitted unless their clinical condition requires it

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Consistent community offer to support people staying independent at home for as long as possible. Involving voluntary sector services, strength-based support systems (including social prescribers) and active interventions such as intermediate care and reablement as a step-up service.	ASCOF - The proportion of older people (aged 65 and over) at home 91 days after discharge from hospital into reablement / rehabilitation services				Community Provider Network
B)	Admission avoidance/ACPs for ambulance service and hospital front door, with a front door discharge to assess approach. Adhering to any end-of-life plans in the universal care plan where the patient has chosen to die at home or other non-hospital setting.					Local UEC Board
C)	Understanding patient behaviours and how this drives their decision making in times of urgent need					Local UEC Board
D)	Review our key existing pathway to avoid admissions e.g. urgent community response (UCR) offer, reablement, MH crisis offer, virtual wards to ensure we are optimising available capacity. Clear access criteria and can be referred from ED.					Local UEC Board

Patient experience of discharge project

An innovative multi-agency project has been established to gain in-depth intelligence about patient experience of discharge. This will help partners understand how best to improve discharge, with a focus on effective communication and consultation with patients. Community researchers recruited by the voluntary sector have been trained in ethnographic interviewing techniques by a specialist research company. They will accompany a sample of patients during their discharge from hospital and ask them about how they are experiencing the process, what they have been told and understand about what is happening and interview two weeks later to understand what actually happens. The report is expected to be available in July.

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.

Estimates for demand and capacity in intermediate care services are based on latest service data projected forward.

The learning from 2022/23 is that we are currently not able to populate the data fields in the national Capacity and Demand template in a consistent and accurate manner. For example, discharge information at a borough level by pathway and service received is not generated by acute data systems. In addition, the local community health provider has had major IT/IS system failures during the year and has been unable to report. This remains an area for development during 2023/24 that is expected to be resolved in the autumn of 2023.

The main source of information used for assessing gaps between demand and capacity for intermediate care is real time operational data of the internal flow hubs, which provides details on all currently delayed patients including the identified reason for the delay. This tells us for the acute delays the key delay reasons relating to care packages (as opposed to delays relating to ongoing NHS care) are as follows:

- availability of suitable care home placement able to meet high levels of acuity in patients
- availability of bed based rehabilitation for those with highest needs who cannot be supported at home
- capacity of community health services to take discharge referrals for therapy at home

Discharges from mental health inpatient settings are most frequently caused by lack of capacity in supported housing providers who are able to support high needs individuals upon discharge. Homelessness and NRPF is also a common factor.

It is a known risk that the lack of capacity in specific areas may result in discharges into services that are not the ideal match for assessed needs, as well as delays in the discharge itself.

These identified gaps are in the process of being addressed through the BCF funding, in particular the Additional Discharge Fund and associated commissioning strategies including:

- Commissioning of new nursing home in borough and initiatives to maximise capacity across the nursing home and residential home bed base
- Development by council of more specialist bed based reablement care services as set out on page 6
- Extra care / flexi care / step down flats
- ICB commissioning plans for rehab beds for pathway 2 and 3 discharges for both acute and mental health under development
- Funding of Kings Outreach Therapy service to provide additional therapy support to discharge when the local community health provider is unable to accept a referral
- Recruitment and retention initiatives (Care Home Charter)
- Homelessness discharge scheme

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

Southwark has the highest rate of discharges to usual place of residence in London. To support our strong home first ethos, the following BCF funded services will actively support discharge to normal place of residence, providing options for care packages that make returning home a safe and effective transfer.

- Internal flow hubs pursuing home first discharge to assess approach
- Reablement services including double handed care
- Community Health @home service and rehabilitation/ intermediate care
- Home care, including overnight intensive home care (Night Owls)
- Residential care and nursing care and flexi care/ extra care
- Step down flats
- 7 day hospital discharge team
- ICES and Telecare
- VCS services such as Hospital Buddies
- DFG including handy person service
- Palliative care at home service

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

High Impact Changes Model for transfers of care

The High Impact Changes Model is a framework for identifying potential improvements across key aspects of the hospital discharge process. Aspects of the model are included in the SEL ICS improvement plan, and the model is used in Southwark as a tool to benchmark for good practice and to help identify service improvement priorities. A recent update against the criteria confirmed that current arrangements still fall into the mature or established banding for each change area. Areas for potential further improvement to be explored include:

Change 1: Early discharge planning

- Ensure people at high risk of admission have discharge plans in place
- Internals flow hubs to ensure full compliance with the setting of expected dates of discharge and an MDT plan, ensuring effective discussion and communication of this, including with family/friends, with preparation during hospital stay to effectively provide a safe discharge
- Ensure new providers implement the red bag scheme promptly

Change 2: Monitoring and responding to system demand and capacity

- Further develop analysis of demand and capacity to enable more sophisticated and long range forecasting
- Develop data systems to enable effective use of intermediate care capacity and demand model
- Maintain contracting with 10 core providers of home care for the borough to ensure capacity to respond to pathway 1 packages of care in a timely manner.

Change 3: Multi-disciplinary (MDT) working

- Primary care involvement in the MDT for discharge planning where required

Change 4: Home first / discharge to assess

- Ensure nursing capacity in the community to do complex assessments
- Further develop reablement and rehabilitation offer in terms of response times and level of care
- Ensure continuation of strong home first approach despite pressures on system, commissioning additional capacity as required from discharge funding
- Review Intermediate Care Southwark pathway to ensure appropriate patients are referred and receive care within best practice timeframes

Change 5: Flexible working patterns

- Build an integrated 7 day service model, increasing the number of patients leaving with packages of care at weekends
- Ensure the internal flow hubs at both acute hospital sites working seven days a week, with access to clinical and social care colleagues to support decision making regarding discharge arrangements.

- Review need and costs/ benefits of expanded 7 day working across more teams in trusts, providers and community health
- Enable more care packages to start at weekends

Change 6: Trusted assessment

- Ensure Trusted Assessor (TA) model is fully embedded with continued use of TA documentation as standard practice by discharge hubs in format agreed with care homes

Change 7: Engagement and choice

- Ensure choice protocol (Safe to Transfer Discharge Policy) that was signed off across SEL in April 2023 is fully embedded and operating effectively

Change 8: Improved discharge to care homes

- Respond to recommendations from Care Home listening event in early 2023
- Development of Transfer of Care (TOC) Passport which provides essential information about a patient for care homes, so they are confident in receiving the admission with all necessary information on arrival.
- Enable more weekend discharges to care homes
- Maximise commissioning options to increase care home capacity to accommodate complex needs, including options from use of discharge fund

Change 9: Housing and related services

- Ensure expected dates of discharge incorporate housing related needs
- Continuation of homeless health project to facilitate discharges
- Extend model of housing advice workers with discharge teams to mental health

These changes will be picked up under workstreams including the Lambeth and Southwark Discharge Operational Delivery Group, the ICS Discharge Solutions Group and mental health discharge group, and specific discharge related workstreams. The changes will be absorbed into the SEL ICS discharge improvement plan monitoring

National Condition 3 (cont)

Care Act and Supporting Unpaid Carers

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?

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.

Funding from the BCF for carers and Care Act duties

A total of £1.95m of BCF funding is targeted at carers and Care Act duties.

The BCF from its inception in 2015/16 has included an allocation of £1m from the NHS minimum contribution to the council to meet additional costs arising from the Care Act.

In addition, £400,000 is allocated to the local VCS (Southwark Carers) for the provision of respite and £450,000 for the costs of carers assessments and services. From 2021/22 an additional £100,000 of annual uplift was targeted at the identified priority area of supporting carers of people with dementia.

Supporting unpaid carers.

Services

There are currently estimated to be 25,700 carers in Southwark

The Voluntary Community Sector (VCS) support for carers, provides information and advice on carers rights, advocacy, accessing grants, legal advice, employment information and advice, accessing statutory services and contingency planning. Carers can access one to one emotional support, as well as enjoy a range of activities and groups, trips and outings, for wellbeing, social interaction and peer support.

There is a dedicated service for young carers, which provides emotional and practical support to young carers with caring responsibilities. This service is funded from the council's general fund to support (currently) 223 young carers registered in Southwark, 53 of which have been supported through one to one activities (workshops, respite, etc) in the past year.

Both commissioned services help to improve identification of "hidden" carers and to raise awareness of the impact of caring.

Southwark has commissioned ADASS Proud to Care online scheme to provide a wide range of discounts to paid and unpaid carers in Southwark amongst other boroughs. Southwark is able to add local businesses to the scheme. Unpaid carers receive assistance from the Voluntary Community Sector to access the scheme.

As of February 2022, carers and foster carers in Southwark have access to a 24 hour helpline which offers confidential, professional support and advice around; health and wellbeing, money worries, self-care and respite, consumer and legal issues, family and home, work and life.

Carer training

In 2022 The Institute of Public Care completed carer training for staff across ASC, Ageing Well Southwark and Commissioning. The workshops were co-produced with carers and representatives from the voluntary sector. The newly designed carer pathway will embed the ethos, principles and approach in order to further:-

- Understand and overcome the challenges to carer identification.
- Have skilled strengths based conversations, supporting carers to access resources to sustain the caring relationship and their own wellbeing.
- Use a more creative and person centred approach to support planning and use of direct payments

Disabled Facilities Grant (DFG) and wider services

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

The DFG service is based within Southwark Council's Private Sector Housing & Adaptations Team and delivered through the Home Improvement Agency (HIA). It is funded by a ring-fenced grant paid to the council for the discharge of its statutory duties to administer a DFG scheme. The DFG supports people with disabilities who are owner-occupiers (who may be asset rich and cash poor) and tenants of private rented/housing association housing by funding physical adaptations to their homes that enable them to remain long term in their own home in the community, avoiding admissions to hospital and care homes. As well as major adaptations the DFG also funds a handyperson service which works closely with the hospital discharge teams to enable people to return home from hospital when their house needs minor repairs. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes.

The Disabled Facilities Grant has been awarded a budget of £1.686m for 23/24, which is the same allocation funding for 22/23. In real terms this can be seen to be a decrease in funding with the rise in costs of materials etc. Growth has been focussed on securing an increase in senior occupational therapist capacity to reduce delays and increase the number of people accessing DFG's.

In 22/23 the focus has been working on clearing the backlog of cases and dealing with any urgent / emergency cases. The financial means test for DFG applications continues to be temporarily waived. The overall delivery process has also been reviewed and improvements implemented. Financial counsellors continue to support applicants and provide assurance with safety etc. For 23/24 we will continue to focus on clearing our backlog of cases, which currently stands at 51 cases on the waiting list, and ensuring emergency cases are dealt with immediately. The team continues to reduce the number of people on the waiting list by reducing the time clients are waiting, which currently stands at 6 months, we intend to reduce this to four months, by working through cases more efficiently. We received a total of 93 referrals from OT, on average 8 per month, during April 22 to March 23.

From April 22 to April 23, we have completed 123 major adaptations, which compromised of:

- 82 Level access showers
- 22-bathroom alterations
- 12 step/ stairlift installations
- 3 Closomat installations
- 3 building alterations
- 1 Door entry system

We have set a target of 150 major completions in 2023/24.

The DFG Service works with adult social care by having joint meetings bi-monthly to specifically discuss complex cases and every 3 months to discuss the progress of cases and complex cases, staffing etc

Other specific areas of improvement:

- The DFG service has now gone to advertising to recruit a Senior Occupational Therapist. The role will work across new homes, the HIA service and voids. This will

help increase the number of OT assessments, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues.

- The DFG service continues to work with a fast track system that has been put in place to ensure cases assessed as urgent or end of life are prioritised.
- The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation.
- The service has updated reporting on Case manager, the IT system used to record adaptation works, this is to monitor progress of cases and ensure progress is made in a timely manner.
- The service implemented satisfaction surveys for completed works. From April 22 to March 23, 46 satisfaction surveys were completed for HIA, respondents said they were happy with the service. Some of the comments were

'I would recommend the service', 'the HIA provided an excellent service'.

The case studies below illustrate how DFGs can benefit service users:

CASE A

Client is female in her 60's and a Housing Association tenant living by herself. Client receiving palliative care at home. Client was referred to the Home Improvement Agency following an Occupational Therapists assessment, the outcome of the assessment recommended the provision for level access shower facilities with wall mounted drop down seat and grab rails.

The adaptations installed had a positive effect allowing the client to maintain her independence, dignity and privacy. Client was very happy with her new bathroom and was satisfied with the overall service. Client stated that the contractor's work was excellent, they were polite and very helpful. Client had a positive experience therefore felt able to recommend the service to others.

CASE B

Client has a range of health issues including multiple sclerosis, collagenous colitis, kidney failure, lupus, breast and lung cancer. The client was assessed by Occupational therapy to replace the bath with a shower, these works were carried out. The client responded to say that the works enabled her to maintain her independence and she was able to shower.

Handy person service.

The handyperson service has been assisting residents, regardless of tenure, (aged 60 or over, or with a disability of any age) with a range of works. The number of works completed between April 22 to March 23, was 1457, which is broken down as follows:

- 444 minor repairs
- 746 Key safes
- 238 Lightbulb changing
- 29 other (decorating, smoke alarms)

Minor repairs include putting up shelves, assembling furniture, moving furniture, which has enabled a new bed or other furniture to be delivered to the persons property.

75% of the key safes installed, approximately – 560 homes, were to enable someone to be discharged from hospital, with approximately just under 200 cases to enable them to receive care in the community. In all cases to enable the resident to remain living in their home.

For 2023/24 our aim is to increase the number of works we carry out across the borough, by promoting the handyperson service to more people including residents living in their own home. We are working with the communication team to put out several adverts across a range of mediums including online newsletters, inserts in council tax and rent statements etc.

From April to March 23, the handyperson service carried out a total of 123 satisfaction surveys. Total satisfaction for the year was at 100%. The consensus from all *'clients was that they trusted the service, happy to get works done, they felt that the service was wonderful and reliable, it enabled them to feel safe, secure at home and enabled them to maintain their independence'.*

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?.

No (focus has been on recovering core DFG waiting list)

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

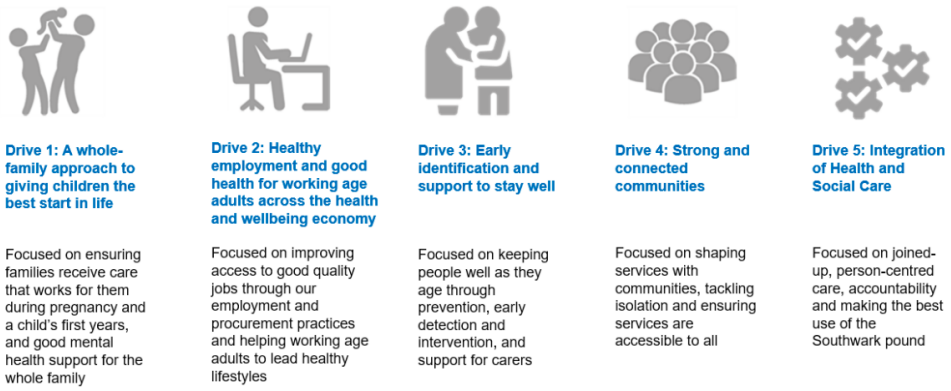
- Changes to local priorities related to health inequality and equality and how activities in the document will address these

- 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.

Supporting the Southwark Health and Wellbeing Strategy

The drive areas included in the refreshed Southwark Health and Wellbeing Strategy agreed by the Health and Wellbeing Board are set out below. These are underpinned by a commitment to ensure tackling inequalities is embedded across all our policy making, service design and delivery.



The key areas in which the BCF will support the refreshed Health and Wellbeing Strategy are as follows:

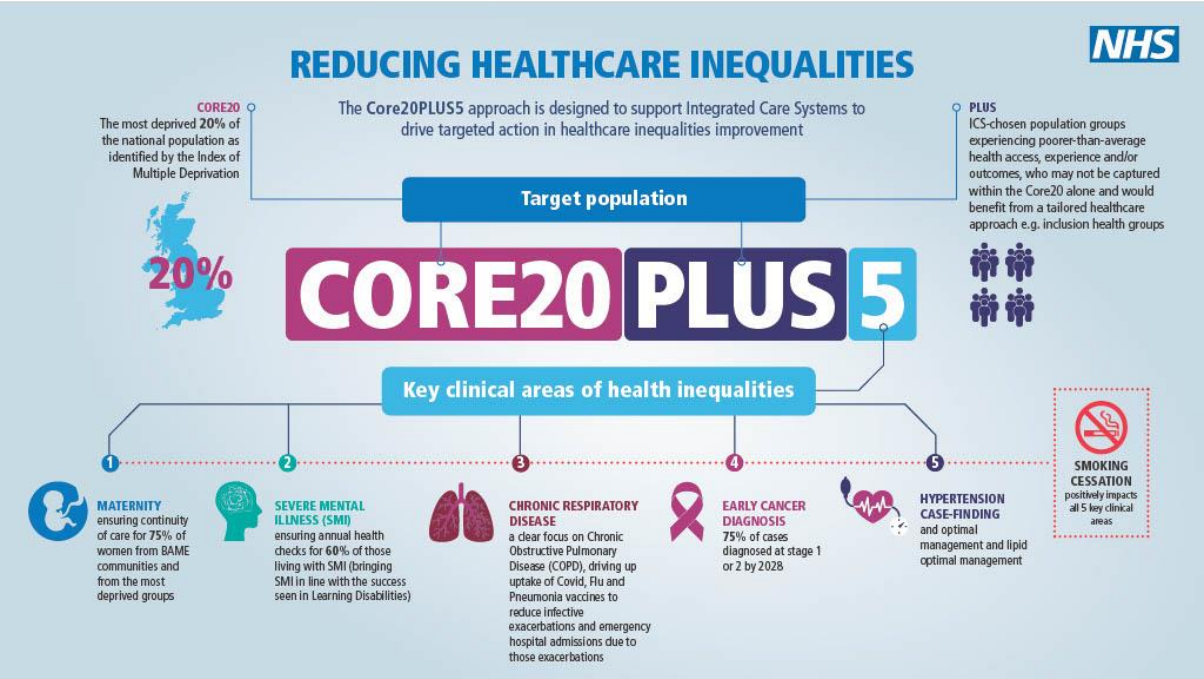
Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy: the BCF provides funding for costs associated with the Southwark ethical care charter, which helps ensure good employment practices in commissioned services.

Drive 3: Early identification and support to stay well: The BCF funds a number of services that have preventative value including the voluntary sector hub, falls prevention, self-management for people with long term conditions and telecare. Also captured under this heading is a range of core out of hospital services funded through the BCF such as rehab and reablement, carers support and hospital discharge support.

Drive 4: Strong and connected communities: BCF funding supports the voluntary sector hub which play a key role supporting strong communities. The vision for integration which the BCF supports includes the development of a strong neighbourhood model which would help promote community resilience.

Drive 5: Integration of Health and Social Care: The BCF is a key pooled budget providing a foundation for the alignment of resources as an enabler of integration. It funds services that have become more integrated e.g. Reablement and Community Health enhanced rapid response have integrated as Intermediate Care Southwark. The draft **Health and Care Plan** and an associated outcomes framework will be developed during 2023/24 and provide detail on the delivery of this drive area. The BCF will be fully aligned with this plan.

Core20PLUS5: It is a priority to develop the capacity to support a Core20PLUS5 approach in 2023/24, working with NHS analytics teams and public health to identify key population groups to target improvements in heath inequalities. This will complement the current Vital 5 programme which focuses on people with key risk factors for poor health outcomes. The Core20PLUS5 approach is illustrated in the diagram below:



The draft Health and Care Plan sets out a commitment to embedding an approach to tackling health inequalities across all our policy-making, services and delivery, including BCF development. It builds on the Partnership Southwark Recovery Plan which sets out the wide range of inequalities in outcomes experienced by Southwark's population which were highlighted and exacerbated by the differential impact of COVID-19 on communities. Addressing inequalities is at the heart of the partnership's 4 key population-based programmes.

The BCF funding is a key enabler of the adult's focused workstreams: live well, age well and care well workstreams, funding a significant range of community based health and care services that are working together to deliver the objectives of the plan.

Contribution to Equalities Act requirements

The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom are reliant on these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of BCF investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities. The Additional Discharge fund has provided resources to extend these principles to the care home workforce through the Residential Care Charter.

Environmental impact of the BCF

Partnership Southwark is committed to developing its approach to sustainability to minimise the adverse impact services have on the environment, particularly in relation to climate change and air quality. This is reflected in the Partnership Southwark Environmental Sustainability Policy Statement in January 2023 which gives a commitment to developing a mutually supportive approach to delivering organisational sustainability plans and ensuring all partnership decisions consider sustainability implications.

According to the Sustainable Development Unit, the NHS is the biggest public sector contributor to climate change in the whole of Europe. Hospitals have a major role to play in this as they have such a high carbon footprint. The BCF has an indirect role in this as it supports the overall strategy of developing a neighbourhood model with health and care closer to home, reducing admissions and minimising length of stay in hospital - which in the long term will shift the balance of resources away from hospital activity. In addition, it is recognised that all community based service providers funded by the BCF have a role to play and will be supported to minimise their environmental impact. For example, the community equipment service has a strong focus on increasing recycling and re-use of equipment.