Health and Wellbeing Surrey

Health and Wellbeing Board
7 September 2017

Surrey Better Care Fund 2017-19

Purpose of the report:

The Surrey Better Care Fund Plan 2017-19 is being submitted to the Surrey Health & Wellbeing Board for approval before submission to NHS England in accordance with the deadline of 11 September 2017.

Recommendations:

That the Health & Wellbeing Board approve the Surrey Better Care Fund Plan 2017-19, enabling its submission to NHS England (NHSE) and the Department of Communities and Local Government (DCLG). The Plan includes:

a. Surrey BCF Narrative plan
b. Surrey BCF Plan Template Annex 1
c. Surrey BCF Delayed Transfers of Care trajectory plan Annex 2
d. Surrey BCF Local narrative plans Annex 3
e. Surrey BCF Local High Impact Change model action plans Annex 4
f. Surrey BCF Risk Log Annex 5
g. Surrey BCF South East Association of Directors of Adult Social Services (ADASS) Summary for assurance process

Introduction:

2. The Better Care Fund (BCF) is a national programme announced by the Government in the June 2013 spending round. The aim of the programme is to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. 2017/18 & 2018/19 will be the third and fourth years of the BCF programme. Local health & wellbeing boards have the responsibility to sign off BCF plans.

3. A new addition to the BCF, called the Improved Better Care Fund (or IBCF) includes an original amount announced in 2015 and an additional allocation announced in the 2017 Spring Budget. The source of this funding is from the DCLG, for the purposes of '*meeting adult social care*

needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.' Beyond these conditions, there is also a requirement to pool the fund as part of the Better Care Fund.

Better Care Fund Plan 2017-19 requirements

4. The Better Care Fund guidance and templates for 2017-19 were published on 4 July 2017 with a deadline to submit a final plan, signed off by local health & wellbeing boards by 11 September 2017.

5. Feedback will be received through a regional assurance process led by NHSE which includes moderation involving the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). There will only be one stage to the assurance process this year and BCF plans will be either:
   a. Approved
   b. Approved with Conditions
   c. Not approved

6. Before submission of this final version to Surrey Health & Wellbeing Board, this Plan has been agreed at the following multiagency forums:
   a. Surrey Health & Social Care Integration Board
   b. Local Joint Commissioning Groups
   c. Clinical Commissioning Group (CCG) governing bodies
   d. Local A&E Delivery Boards (for High Impact Change models)

7. Surrey's BCF plan (2017-19) creates a pooled fund for health and care integration from the various funding sources.

   a. The total pooled fund, including funding sources are:

	2017/18 Gross Contribution	**2018/19 Gross Contribution**
Total Local Authority Contribution exc iBCF	£8,031,076	£8,713,132
Total iBCF Contribution	£7,542,801	£7,894,843
Sub total LA contribution	£15,573,877	£16,607,975
Total Minimum CCG Contribution	£67,359,827	£68,639,664
Total Additional CCG Contribution	£144,959	£140,442
Sub total CCG contribution	£67,504,786	£68,780,106
Total BCF pooled budget	**£83,078,663**	**£85,388,081**

b. As mentioned above, the grant conditions for the new IBCF are: '*meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.'* The countywide approach to meet these conditions was an agreement to use it as a contribution to a ring-fenced fund for supporting hospital discharge with social care packages of care which will also support the local provider market.

c. The use of all BCF funds will be formalised by Section 75 agreements between Surrey County Council and the CCGs. There is an NHSE requirement that these are signed off by 30 November 2017. Though the plan is not yet signed off, submitted or approved; planning is already underway with partners to achieve this ambition.

8. NHSE have set out four national conditions, which the countywide and local narrative plans and the expenditure plan in the BCF template have been built around:

   a. Plans to be jointly agreed
   b. NHS contribution to adult social care is maintained in line with inflation
   c. Agreement to invest in NHS commissioned out of hospital services
   d. Managing transfers of care

9. NHSE have set out four National metrics, which are included in the BCF template:

   a. Non Elective Admissions (targets from CCG operating plans)
   b. Care Home Admissions (targets agreed locally)
   c. Reablement 91 day Review (targets agreed locally)
   d. Delayed Transfers of Care (targets now set by NHSE)

10. There will again be a requirement for reporting of the BCF and iBCF funds on a quarterly basis. The approach taken in Surrey will be the same as in previous years which is to compile the report with support from performance colleagues across the local authority and CCGs, and sign off through members of the Health & Social Care Integration Board, acting on delegated authority from the Health and Wellbeing Board with final submission to be shared with the Health and Wellbeing Board for information.

Better Care Fund Plan 2017-19 approach

11. The BCF plan for 2017-19 builds on the progress made in 2015/16 and 2016/17, under the leadership of the Health & Wellbeing Board. The Board has been a primary means to establish relationships based on mutual trust and respect.

12. The BCF will continue to be planned and delivered in partnership across Surrey's health and care system. Over the past two years the BCF has provided Surrey with significant opportunities and challenges – as a

system, a huge amount has been learnt from the experience in developing plans, negotiating and agreeing governance arrangements, as well as through the implementation of plans. Governance and accountability arrangements in the Surrey system are now well matured and have served well in the building of STPs and will drive the delivery of integration across Surrey in the coming years.

13. Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles provide evidence of rising demand from an aging population and increased numbers of people living with complex needs and long term conditions.

14. The Surrey BCF Plan 2017/18-2018/19 maintains the same focus on older adults as previous plans though also addresses priorities within the Health & Wellbeing Strategy to promote mental and emotional wellbeing as well as the development of preventative approaches.

15. To achieve the vision three strategic aims for the BCF have been agreed:
    a. 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.
    b. Enabling people to stay at home - integrated care delivered seven days a week through enhanced primary and community services which are safe, effective and increase public confidence to remain out of hospital or residential/nursing care.
    c. 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.

16. Surrey's single Health and Wellbeing Strategy has been aligned to local BCF plans. Commissioning and planning continues at local (through Local Joint Commissioning Groups - LJCGs), STP and Surrey level, using a principal of subsidiarity, which depends on the consistency in need, appropriate levels for intervention and the provider market. Local plans are shown in the Local Narrative plans, Local High Impact Change models and the BCF planning template.

17. There are a number of examples in each area's local BCF plans which support the vision of ever closer integration between health and social care. One example is that BCF funds hospital-based social care teams and reablement, both which are key in supporting early hospital discharge and support in a community setting. The BCF also supports local integrated services, where multiple professionals are coming together to support individuals, with care planned around the individual, across organisational boundaries.

    a. In East Surrey, continue to build on the multidisciplinary team (MDT) approach to patient management, ensuring that relevant patient health information is shared across the appropriate agencies. The aim of this service is to facilitate a consistent and

coordinated approach to care, preventing unnecessary conveyances, and emergency admissions into secondary care, with care being delivered in the most appropriate setting.

b. In Guildford & Waverley, progress against the priority of supporting frail older people in the community, will continue to be delivered through the local Proactive Care Service hubs established in the two local geographies of Guildford and Waverley. Trusted assessment of frail patients takes place within this service between health and social care, with weekly MDT meetings to discuss management of patients with GP Frailty leads. This results in more intensive management of the frail older over time with more resources focused on supporting this group of patients in the community and preventing acute hospital admission.

c. In the North East Hampshire & Farnham Vanguard model of care, the vision is to: (1) strengthen focus on self-care and prevention (2) enhance primary care and multi-disciplinary locality teams (3) improve local access to specialist expertise and care and (4) create a shared care record.

d. In North West Surrey, continue the implementation of the Model of Care under the fundamental design principles of: people-centred integration of health and care services; whole system care navigation; sustainability of our Acute Trust; mental health equality; provide care at the most appropriate place; age-appropriate care; transition of Children and Young People into adult services

e. In Surrey Downs, its three localities' will continue to develop around (1) Community Medical Teams (CMTs) run by local GP networks, (2) Community Hubs including statutory (health and social care) and voluntary services to manage a case load of high risk individuals identified through acute exacerbations and risk stratification and (3) Provision of enhanced multi-disciplinary support to prevent admission to hospital and provide early supported discharge.

f. In Surrey Heath's Integrated Care teams (1) they will use a risk stratification approach, (2) individuals on the caseload to have a named care co-ordinator, (3) social care referrals from professionals to be included in the Single Point of Access, (4) rapid response and reablement to work more closely together, (5) fully integrating dementia navigators within the dementia pathway and (6) sharing of information and care plans across providers where appropriate.

Conclusions:

18. It is judged that the attached full BCF plan meets the requirements set by NHSE and DCLG, and following agreement from Surrey's Health and Wellbeing Board, will be ready for submission on 11 September 2017.

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Next steps:

19. If the BCF Plan 2017-19 is agreed by Surrey's Health & Wellbeing Board it will be submitted to NHSE and DCLG for approval by 11 September 2017.

20. Following plan submission and approval, Section 75 agreements between Surrey County Council and CCGs can be signed to achieve the NHSE ambition of having these signed by 30 November.

Report contact:
Andre Lotz
Project Manager Health and Care Integration
Adult Social Care & Public Health
Surrey County Council

Contact details:
Email: andre.lotz@surreycc.gov.uk
Tel: 0208 541 7571

Annexes:

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