Notice of Meeting

Health and Wellbeing Board

Date & time	Place	Contact
Thursday, 6 February 2014 at **1.00 pm**	Committee Room C, County Hall, Kingston upon Thames, Surrey KT1 2DN	Huma Younis Room 122, County Hall Tel 020 8213 2725 huma.younis@surreycc.gov.uk

If you would like a copy of this agenda or the attached papers in another format, eg large print or braille, or another language please either call 020 8213 2725, write to Democratic Services, Room 122, County Hall, Penrhyn Road, Kingston upon Thames, Surrey KT1 2DN, Minicom 020 8541 8914, fax 020 8541 9009, or email huma.younis@surreycc.gov.uk.

This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Huma Younis on 020 8213 2725.

Board Members

Mr Michael Gosling (Co-Chairman)	Cabinet Member for Public Health and Health and Wellbeing Board
Dr Joe McGilligan (Co-Chairman)	East Surrey Clinical Commissioning Group
Mrs Mary Angell	Cabinet Member for Children and Families
Helen Atkinson	Public Health
Dr Andy Brooks	Surrey Heath Clinical Commissioning Group
Dr David Eyre-Brook	Guildford and Waverley Clinical Commissioning Group
Dr Claire Fuller	Surrey Downs Clinical Commissioning Group
Dr Liz Lawn	North West Surrey Clinical Commissioning Group
Dr Andy Whitfield	North East Hampshire and Farnham Clinical Commissioning Group
Dr Jane Dempster	North East Hampshire and Farnham Clinical Commissioning Group
Nick Wilson	Director,CSF
Councillor James Friend	Mole Valley District Council
John Jory	Reigate and Banstead Borough Council
Councillor Joan Spiers	Reigate and Banstead Borough Council
Chief Constable Lynne Owens	Surrey Police
Peter Gordon	Healthwatch

TERMS OF REFERENCE

The Health and Wellbeing Board:

- oversees the production of the Joint Health & Wellbeing Strategy for Surrey;
- oversees the Joint Strategic Need Assessment; and
- encourages integrated working.

PART 1
IN PUBLIC

1 APOLOGIES FOR ABSENCE

2 MINUTES OF PREVIOUS MEETING: 12 DECEMBER 2013 (Pages 1 - 6)

To agree the minutes of the previous meeting.

3 DECLARATIONS OF INTEREST

To receive any declarations of disclosable pecuniary interests from Members in respect of any item to be considered at the meeting.

4 QUESTIONS AND PETITIONS

As the Health and Wellbeing Board is a statutory committee of Surrey County Council, there is an opportunity for Surrey County Councillors and residents to ask questions at the start of the meeting.

- The deadline for questions from County Councillors is 12pm four working days before the meeting *(**31 January 2014**)*.
- The deadline for public questions is seven days before the meeting (***30 January 2014***).
- The deadline for petitions was 14 days before the meeting. No petitions have been received.

5 FORWARD WORK PROGRAMME (Pages 7 - 8)

To consider the Board's Forward Work Programme and agree the agenda for the next meeting on 13 March 2014.

6 BOARD APPROVALS

To receive any board approvals.

7 BETTER CARE FUND DRAFT PLAN (Pages 9 - 38)

The purpose of this paper is to invite the Health and Wellbeing Board to review and sign-off the 'draft' Surrey-wide Better Care Fund plan and to submit to NHS England by 14 February 2014.

8 ALLOCATION & DRAWDOWN OF WHOLE SYSTEMS FUNDING (Pages 39 - 42)

To approve the drawdown and distribution of the NHS England allocation of Whole Systems Funding to Surrey County Council. This report shows how the money is planned to be used and the agreed monitoring arrangements.

9 PUBLIC ENGAGEMENT SESSION

Up to 15 minutes will be allocated for the public engagement session.

David McNulty
Chief Executive
Surrey County Council
Published: Wednesday 29 January, 2014

QUESTIONS, PETITIONS AND PROCEDURAL MATTERS

The Health and Wellbeing Board will consider questions submitted by Members of the Council, members of the public who are electors of the Surrey County Council area and petitions containing 100 or more signatures relating to a matter within its terms of reference, in line with the procedures set out in Surrey County Council's Constitution.

Please note:

1. Members of the public can submit one written question to the meeting. Questions should relate to general policy and not to detail. Questions are asked and answered in public and so cannot relate to "confidential" or "exempt" matters (for example, personal or financial details of an individual – for further advice please contact the committee manager listed on the front page of this agenda).
   The Public engagement session held at the end of the meeting is made available to Members of the public wanting to ask a question relating to an Item on the current agenda. Questions not relating to items on the agenda will need to be submitted in advance of the meeting.
2. The number of public questions which can be asked at a meeting may not exceed six. Questions which are received after the first six will be held over to the following meeting or dealt with in writing at the Chairman's discretion.
3. Questions will be taken in the order in which they are received.
4. Questions will be asked and answered without discussion. The Chairman or Board Members may decline to answer a question, provide a written reply or nominate another Member to answer the question.
5. Following the initial reply, one supplementary question may be asked by the questioner. The Chairman or Board Members may decline to answer a supplementary question.

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

Those attending for the purpose of reporting on the meeting may use social media or mobile devices in silent mode to send electronic messages about the progress of the public parts of the meeting. To support this, County Hall has wifi available for visitors – please ask at reception for details.

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It is requested that if you are not using your mobile device for any of the activities outlined above, it be switched off or placed in silent mode during the meeting to prevent interruptions and interference with PA and Induction Loop systems.

Thank you for your co-operation

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MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 1.00 pm on 12 December 2013 at Old Council Chamber,Reigate & Banstead BC, Town Hall, Castlefield Road, Reigate, RH2 0SH.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 6 February 2014.

Elected Members:

*	Mr Michael Gosling (Co-Chairman)
*	Dr Joe McGilligan (Co-Chairman)
A	Mrs Mary Angell
*	Helen Atkinson
*	Dr Andy Brooks
*	Dr David Eyre-Brook
A	Dr Claire Fuller
*	Dr Liz Lawn
A	Sarah Mitchell
*	Dr Andy Whitfield
*	Dr Jane Dempster
*	Nick Wilson
*	Councillor James Friend
*	John Jory
*	Councillor Joan Spiers
*	Chief Constable Lynne Owens
*	Peter Gordon

Substitute Members:

Mr Dave Sargeant
Mr Steve Loveless
Mr Keith Edmunds

37/13 APOLOGIES FOR ABSENCE [Item 1]

Apologies had been received from Dr Claire Fuller, Mrs Sarah Mitchell (for whom Dave Sargeant substituted) and Mrs Mary Angell.

In the absence of Dr Claire Fuller and her substitute, Mr Steve Loveless and Mr Keith Edmunds were in attendance from Surrey Downs CCG.

38/13 MINUTES OF PREVIOUS MEETING: 5 SEPTEMBER 2013 [Item 2]

1. Referring to paragraph 3, page 4 of the minutes, a Member of the Board asked for there to be more clarification around the follow up to the actions discussed at the meeting.

2. The Chairman agreed that he and the Lead Manager for Health and Wellbeing would follow this up.

39/13 DECLARATIONS OF INTEREST [Item 3]

There were none.

40/13 QUESTIONS AND PETITIONS [Item 4]

There were none.

41/13 FORWARD WORK PROGRAMME [Item 5]

Witnesses:
None

Key points raised during the discussion:

1. The Chairman explained that the forward work programme is a working document that would inevitably change for both the March and June meetings. Board Members were told that an extra public meeting would be held on 6 February 2014.

Resolved:

a) The forward work programme was noted.

Actions/Next Steps:
None

42/13 BOARD APPROVALS [Item 6]

Witnesses:

None

Key points raised during the discussion:

1. As part of the County's winter preparation for 2013/14, the Chairman expressed the importance of having an integrated health system between partners. If any Members had any concerns around winter preparation they were asked to raise this with the Board.

Resolved:

a) The Board noted the preparations for winter 2013/14 letter.

Actions/Next Steps:

None

43/13 REVIEW OF FORECAST BUDGET POSITIONS [Item 7]

Witnesses:

Marie Farrell, Director of Finance at NHS England Surrey and Sussex Area Team

Key points raised during the discussion:

1. A presentation detailing the budget positions of each of the Clinical Commissioning Groups, Surrey County Council, Surrey Police and Surrey's District and Borough Councils was presented.
2. It was explained that the Police's forecast budget position for the year was for a balanced budget. A large amount of the budget went towards covering employee costs with future plans to increase capacity in domestic abuse, cyber crime and public protection.
3. Surrey Police raised concerns around the gap in mental health care and asked the Board to discuss issues around support for mental health care patients in custody. The Chairman advised that he would meet with the Chief Constable to discuss these issues.
4. The Clinical Commissioning Groups reported on the work that was ongoing to achieve the surpluses they were expected to deliver in their budgets. This was largely successful, although it was noted that this might prove difficult for some of the CCGs.
5. Members of the Board discussed the Integration Transformation Fund (ITF) and how the funds included would be used. The Director of Finance at NHS England Surrey and Sussex Area Team explained that the ITF was now known as the Better Care Fund and that the funding for this had come from existing budgets. There would be scope for local stakeholders to agree on how the pooled budget for the Better Care Fund is used.
6. The Chairman explained that the Board would hold further discussions regarding the Better Care Fund. If there were any further changes to budget positions, Board Members were asked to make the Lead Manager of Health and Wellbeing aware of these.

7. The Chairman explained that the amount of funding spent on each of the Health and Wellbeing Board's five key priorities would depend on how each of the priorities developed over time.

Resolved:

a) The presentation was noted

Actions/Next Steps:

a) Members were asked to let the Lead Manager of Health and Wellbeing know if there were any changes to budget forecasts.

44/13 SURREY SAFEGUARDING ADULT BOARD ANNUAL REPORT [Item 8]

Witnesses:

Simon Turpitt, Independent chair of Surrey Safeguarding Adults Board

Key points raised during the discussion:

1. A presentation was given to Members of the Board. The presentation gave an overview of the Surrey Safeguarding Adults Board Annual Report including highlights of the year, challenges and plans for the future. It was explained that a new Chairman had been in place since July 2013 and was happy with the priorities that had been set for the current year.
2. It was commented that the location of alleged abuse towards adults was increasingly found within the own home and within care homes. The Surrey Safeguarding Adults Board was working with care homes to ensure training was provided to care workers.
3. There were concerns raised over the low level of safeguarding referrals made by the Asian or Asian British community in Surrey. The Board agreed on the need to remove communication barriers and improve access into the Asian and Asian British community in Surrey.
4. Some Members of the Board expressed the need to understand the cultural reasons as to why the Asian or Asian British community in Surrey did not make referrals to the Safeguarding Board. The low level of referrals was a concern for the Independent Chair of Surrey Safeguarding Adults Board who stated that more needed to be done to ensure that the group was protected.
5. Referrals from GP's to the Surrey Safeguarding Adults Board were low and more engagement with GP's was required to increase referral numbers.

Resolved:

a) The presentation was noted.

b) That Board Members take the annual report's priorities back to their respective organisations and consider the implications on service development and working practices.

Actions/Next Steps

a) Board Members were asked to contact Independent chair of Surrey Safeguarding Adults Board if there were any further questions.

45/13 SURREY SAFEGUARDING CHILDREN BOARD ANNUAL REPORT [Item 9]

Witnesses:
Nick Wilson, Strategic Director for Children, Schools and Families

Key points raised during the discussion:

1. The report was introduced by the Strategic Director for Children, Schools and Families. The Surrey Safeguarding Children Board (SSCB) annual report 2012/2013 reports upon the effectiveness of safeguarding and child protection practice by partner organisations in Surrey.
2. The Board has introduced a number of policies and procedures which have been endorsed by partners. One of these key priorities is to focus on reducing incidences of domestic violence on children, young people and families.

Resolved:

a) The presentation was noted.
b) It was agreed that Board Members would take the annual report's priorities back to its respective organisations and consider the implications on service development and working practices.

Actions/Next Steps

a) Board Members were asked to contact Independent chair of Surrey Safeguarding Children Board if there were any further questions.

46/13 UPDATE PAPER: CHILDREN'S HEALTH & WELLBEING PRIORITY [Item 10]

Witnesses:
None

Key points raised during the discussion:

1. Following on from the discussion at its previous meeting on 5 September 2013, the Board received an update on progress towards developing Surrey's Health and Wellbeing Strategy priority to improve children's health and wellbeing.
2. The Board was asked to endorse the approach and way forward for the aims and outcomes of the Children's Health and Wellbeing priority. This approach recognised the commissioning responsibilities and

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governance arrangements of individual member organisations of the Board and set out the next steps for delivery through the Children's Health and Wellbeing Group and Surrey Children and Young People's Partnership.

Resolved:

It was agreed that the Health and Wellbeing Board,

a) Endorsed the approach for taking forward the Children's Health and Wellbeing priority aims and outcomes.
b) Would consider a progress report in March 2014

Actions/Next Steps
None

47/13 PUBLIC ENGAGEMENT SESSION (Q&A) [Item 11]

Witnesses:
Michael Wilson, CEO, Surrey & Sussex Healthcare (SASH) NHS Trust
Alan McCarthy, Chairman, Surrey & Sussex Healthcare (SASH) NHS Trust

Key points raised during the discussion:

1. The Board was updated on the work of SASH and its plans to become a Foundation Trust. The presentation described SASH as a strong national performer in the national performance framework and set out how it is engaging more with the local community in a bid to increase support for the Trust. The Trust has seen an increase in patient numbers and has looked to increase and develop a number of joint ventures.
2. SASH stated that they could only become a foundation trust if they were financially stable and had firm and sustainable relationships with commissioners.

Resolved:
None

Actions/Next Steps
1) SASH to follow up with Borough and District Councils to promote SASH Foundation status plans on their websites.
2) The Chairman invited SASH back to the Board at a later date.

Chairman

Meeting dates	**6 Feb 2014 PUBLIC**	**13 Mar 2014 PUBLIC**	**3 April 2014 PUBLIC**	**5 June 2014 PUBLIC**
Time & Venue	**1-2pm County Hall, Committee Rm C**	**1-4pm Reigate & Banstead Town Hall**	**1-2pm Guildford and Waverley CCG, Dominion House, Guildford**	**1-4pm Reigate & Banstead Town Hall**
Planned agenda items	Better Care Fund Draft Plan Allocation and Drawdown of Whole Systems Funding	JHWS Priority Plan: developing a preventative approach Report from outcomes group (JSNA steering group): 1) progress review of Emotional wellbeing and mental health priority 2) progress review of children and young people priority Self Assessment Frameworks for Autism and Learning Disabilities	JHWS Priority: Older Adults Health and Wellbeing – sign off Better Care Fund Final Plan – sign off	JHWS Priority Plan: safeguarding the population Report from outcomes group (JSNA steering group): 1) progress review of Older adults priority
30 mins	*15 mins: Public engagement session*	Public engagement session	Public engagement session	Public engagement session

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Health and Wellbeing Surrey

Surrey Health and Wellbeing Board

Date of meeting	6 February 2014

Surrey-Wide Better Care Fund Plan

Purpose of item / paper	The purpose of this paper is to invite the Health and Wellbeing Board to review and sign-off the 'draft' Surrey-wide Better Care Fund plan and to submit to NHS England by 14 February 2014. The LGA and NHS England's guidance on the Better Care Fund sets out the expectation that the plan will be agreed between the County Council and Surrey's Clinical Commissioning Groups and will be signed off by the Health and Wellbeing Board. The draft plan must be submitted to NHS England by 14 February 2014, with the final version submitted as part of the overall NHS planning round by 4 April 2014. Surrey has established six Local Joint Commissioning Groups – one for each of the six Clinical Commissioning Group areas, with membership from the local health and social care community. These Groups will be responsible for Better Care Fund investment decisions, the joint commissioning of services and oversight of the operational delivery of schemes. Planning is well underway with workshops held in November – January and each of the Local Joint Commissioning Groups developing a local Better Care Fund Plan setting out their joint health and social care work programme. The decision to develop local joint work programmes is designed to enable each area to address the range of different communities in Surrey; from urban to rural, the needs of these specific communities, the different histories, patterns of service provision, service providers, strengths, needs as identified in the Joint Strategic Needs Assessment and challenges, as well as the need for local ownership and leadership. The attached plan is a 'draft' composite Surrey-wide plan. It provides an overview of key themes from each of the six local joint work programmes and gives examples of how the enhanced and integrated model of community based health and social care in Surrey will deliver better health, outcomes and experience for the population.

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Surrey Health and Wellbeing priority(ies) supported by this item / paper	The Better Care Fund is designed to improve outcomes for vulnerable people through better integrated care and support, and a significant expansion of care in community settings. It will achieve this by shifting resources from acute services into preventative services in primary care, community health and social care. The Surrey-wide Better Care Fund plan outlines plans for 2015/16 which will support delivery of all five priorities in Surrey's Joint Health and Wellbeing Strategy and what organisations can do better together. However, the focus of the plan is upon providing better care for older people in community settings. It will therefore have most impact upon the delivery of Priority 4 – 'improving older adults' health and wellbeing'.
Financial implications - confirmation that any financial implications have been included within the paper	The Better Care Fund is a national fund which was announced in the June 2013 Spending Round. The fund is made up of a number of existing elements of funding, most of which will come from health budgets. The announcement covered two financial years: • For 2014/15, the expected Whole Systems Funding for Surrey = £18.3m • For 2015/16, the expected Better Care Funding total position for Surrey is expected to be a revenue allocation of £65.5m + capital of £6.0m = £71.5m in total. Figure 1 – Element of 2015/16 Better Care Fund

	Nationally £m	Surrey £m
New Care Bill duties	135	2.56
Carers breaks	130	2.46
Reablement	300	5.68	
Whole systems	1,100	18.30
Balance for allocation	1,795	36.50
	3,460	**65.50**
Capital general	134	2.30
Disabled Facilities Grant	220	3.70
	354	**6.00**

	In 2015/16 the Better Care Fund will be put into a pooled budget under Section 75[1] joint governance arrangements between Clinical Commissioning Groups and the County Council. A condition of accessing the money in the Fund is that Clinical Commissioning Groups and Adult Social Care must jointly agree plans for how the money will be spent, and these plans must meet certain conditions. One of these conditions is to 'protect' (the government's word) social care services. In Surrey it has been agreed that plans will be drawn up on the basis that "the system across Surrey has committed to jointly investing the Better Care Fund to improve services and outcomes for patients and to creating financial benefit as a result. We have agreed to share this benefit for further investment in services and to ensure the sustainable delivery of better care for the future. In 2015/16 we expect the benefit to social care to be £25m".
Consultation / public involvement – activity taken or planned	Throughout 2013/14, health and social care providers have been engaged in developing an integrated vision for out of hospital care in each local area through the five Local Transformation Boards. Whole systems engagement events were also held across Surrey during November and December about new models of care within the context of the opportunities created by the Better Care Fund. Across Surrey, mechanisms are in place for engagement with patients, services users and the public through a number of partnership boards. These include the Surrey Ageing Well Board, the Surrey Learning Disability Partnership Board, local Empowerment Boards and the Local Transformation Boards. Each of the six Surrey Clinical Commissioning Group also has arrangements in place for patient and public engagement, including Patient Reference and Advisory Groups. Each Local Joint Commissioning Group is committed to community engagement and co-design as a key component of its plan for utilising the Better Care Fund and transforming out of hospital care.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	The project team is in the process of undertaking an equality impact assessment. This will be completed and available to the Health and Wellbeing Board alongside the final Surrey-wide Better Care Fund plan.

[1] Section 75 of the NHS Act, provides for CCGs and local authorities to pool budgets

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Report author and contact details	Julia Ross, Chief Executive, NHS North West Surrey CCG Tel 07867 978924 julia.ross@nwsurreyccg.nhs.uk Dave Sargeant, Interim Strategic Director, Adult Social Care Tel: 01483 518441 david.sargeant@surreycc.gov.uk
Sponsoring Surrey Health and Wellbeing Board Member	Andy Brooks, Clinical Chief Officer, Surrey Heath CCG Tel 01276 707572 a.brooks1@nhs.net;
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** Review and sign-off the 'draft' Surrey-wide Better Care Fund plan and to submit to NHS England by 14 February 2014.

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Surrey County Council
Clinical Commissioning Groups	NHS East Surrey CCG
	NHS Guildford and Waverley CCG
	NHS North East Hampshire and Farnham CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS Surrey Heath CCG
Boundary Differences	• The population of North East Hampshire & Farnham CCG straddles the counties of Surrey and Hampshire. The CCG has worked in collaboration with both Surrey and Hampshire County Council and is included in both Local Authority Better Care Fund plans. The CCG's financial allocation has been appropriately split across the two Better Care Fund plans based on population. The CCG has aligned both plans to ensure inequality is minimised. • Due to the nature of patient flow, there are boundary issues that have been considered for East Surrey CCG. The Surrey and Sussex Healthcare NHS

	Trust contract - East Surrey's main acute provider is commissioned with Sussex
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled revenue budget: 2014/15	**£18.3m**
2015/16	**£65.5m**
Total agreed value of pooled revenue budget: 2014/15	**£18.3m**
2015/16	**£65.5m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS East Surrey CCG
By	Mark Bounds
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	NHS Guildford & Waverley CCG
By	
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	NHS North East Hampshire & Farnham CCG
By	Maggie MacIsaac
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	NHS North West Surrey CCG
By	Julia Ross
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	NHS Surrey Downs CCG
By	Miles Freeman
Position	Chief Officer

Signed on behalf of the Clinical	NHS Surrey Heath CCG

Commissioning Group	
By	Dr Andy Brooks
Position	Clinical Chief Officer
Date	<date>
Date	<date>

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Signed on behalf of the Council	Surrey County Council
By	Dave Sargeant
Position	Interim Strategic Director Adult Social Care
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Surrey Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Michael Gosling Dr Joe McGilligan
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Across Surrey, engagement with health and social care providers takes place through the five Local Transformation Boards based around the catchments of the five acute hospitals. These are made up of senior decision makers, both managerial and clinical, from acute, mental health, community, primary care, social care and emergency service providers, plus borough and district councils and representatives from the voluntary sector. As members of the Local Transformation Boards, providers form an integral part of the planning and implementation teams, as well as participating as members of relevant and associated work streams.

With significant patient flows to Kingston Hospital, Surrey Downs CCG is also a member of the Kingston Whole System Partnership Board and Urgent Care Board, which perform a similar function for that area. North East Hampshire & Farnham CCG together with Surrey Heath CCG and Bracknell & Ascot CCG are in the process of liaising with Frimley Park Hospital to consider the potential impacts of the Better Care Fund on the local system over the next 5 years. Ongoing engagement with community providers is also being undertaken.

Throughout 2013/14, health and social care providers have been involved in developing an integrated vision for out of hospital care in each local area through the relevant local Boards. Whole systems engagement events were held across Surrey during November and December, including members of the Boards and were designed to build on previous discussions about new models of care within the context of the opportunities created by the Better Care Fund.

Engagement specifically with the wide range of adult social care providers is primarily conducted through the Surrey Care Association, with discussions planned during the

spring.

To realise the opportunities presented by the Better Care Fund, Surrey has established six Local Joint Commissioning Groups – one for each of the six local CCG areas. These Groups will be responsible for Better Care Fund investment decisions, the joint commissioning of services and oversight of the operational delivery of the schemes set out in their local joint work programme. As part of this, all six Local Joint Commissioning Groups will co-design the future models of care with health and social care providers and will engage in more detailed conversations with them, including individual discussions and negotiations, as part of the process starting in January 2014.

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d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Across Surrey, mechanisms are in place for engagement with patients, services users and the public through a number of partnership boards. These include the Surrey Ageing Well Board, the Surrey Learning Disability Partnership Board and the local Empowerment Boards (primarily focused on working age adults with a physical disability or long term condition). Both health and social care commissioners attend these Boards along with representatives from patient and service user bodies. The Boards consider commissioning and service strategies and service redesign proposals and act as a focal point of engagement across the whole spectrum of health and social care services.

Patient, public and service user representatives also form part of the Local Transformation Boards described above, and through these have been involved in the development of the vision and proposals for out of hospital care in each locality. Patient and public representatives also attended the Surrey-wide Whole Systems Working event in early October 2013, along with staff from commissioners and providers across the health and social care system.

At the CCG level, each of the six Surrey CCGs has arrangements in place for patient and public engagement, with the detailed arrangements varying locally. Engagement mechanisms include Patient Reference and Advisory Groups in each area. Lay members and patient representatives also form part of governing bodies and other governance arrangements. For example:

- In East Surrey CCG, consultation took place with patients and the public during the 2013/14 commissioning plan development, regarding future intentions, including regular meetings with the Patient Reference Group (PRG). This helped shape and validate priorities for the locality, which will be further developed, implemented and embedded during 2014/15. The current Chairman of the PRG is also a member of the Governing Body, ensuring two way communications between the CCG and patient representatives.

- Guildford and Waverley CCG will be utilising its Patient and Public Engagement forums and meetings to test the support and encourage debate on the service model being defined as part of the Better Care Fund.

- North East Hampshire & Farnham CCG held stakeholder events relating to their

local integration plans in November and December 2013, with further events planned. Feedback from these events is reflected in the local joint work programme. North East Hampshire & Farnham is in the process of developing a comprehensive local communication and engagement strategy.

- North West Surrey CCG has an extensive infrastructure to enable patient and public engagement at practice, locality and CCG level. In addition processes are being developed that enable randomised and representative patient feedback from the local population, building on processes already in place with providers and local authorities. The CCG's strategic plan commits to a significant public listening process as plans for change to pathways and service delivery are developed and finalised.

- For Surrey Downs CCG, engagement to date has largely focused on working with membership practices and local providers to identify opportunities to improve standards and re-design care pathways, with a focus on closer integration to make services fully patient-centred. Patient and carer representatives have shaped this work, and have also been involved in specific work programmes. This has included stakeholder engagement as part of the Surrey-wide review of arrangements for continuing health care and the introduction of personal health budgets. The Surrey Downs Out of Hospital Strategy has also taken account of feedback from local people, particularly in relation to services at Epsom Hospital and including involvement in the Better Services Better Value programme.

- Surrey Heath CCG holds quarterly engagement events with its local community and patients, service users, voluntary organisations and members of the public. Meetings in June and September 2013 highlighted the importance the community places on more integrated services across health and social care and have influenced the programmes and projects within the local Better Care Fund plan.

- For Adult Social Care, the mechanisms for engagement include representation from the Surrey disabled people's organisations and Action for Carers Surrey on the overarching Transformation Board and Implementation Board, along with representation on specific project boards and involvement in the development of commissioning priorities.

Each Local Joint Commissioning Group is committed to community engagement and co-design as a key component of its plan for utilising the Better Care Fund and transforming out of hospital care. As commissioners, the six CCGs and Adult Social Care will work together in each locality to communicate the priorities and intentions during February and March, seeking feedback and further opportunities for co-design. Feedback will inform our key priorities, including our Better Care Fund strategy and will shape our plans for 2014/15 and beyond to ensure local services are integrated, responsive, affordable and meeting the needs of local people.

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e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Surrey's Joint Health and Wellbeing Strategy	Sets out the five priorities upon which partners will work together to deliver an innovative and effective health and social care system for Surrey
Surrey's Joint Older People Action Plan	Joint action plan to deliver the 'improving older adult's health and wellbeing priority' set out in Surrey's Joint Health and Wellbeing Strategy
Surrey's Ageing Well Commitment	Describes what ageing well means and what kind of place Surrey needs to be to make it somewhere that people want to live and age in. Challenge our views of older people and looks at the many positives that older people bring to local communities
Surrey's Joint Strategic Needs Assessment	How the CCGs and Adult Social Care identify and describe the health, care and well-being needs of the Surrey population. This assessment is used to inform the prioritisation and planning of services to meet those needs
Adult Social Care Directorate Strategy 2013/14–2017/18	The broad strategic direction for Surrey County Council's Adult Social Care Directorate over the next 5-years
Local Joint Better Care Fund Plans	Local joint health and social care Better Care Fund plans and work programmes
Local Health Profiles	Overview of the local CCG's population in terms of demography, deprivation and specific conditions and behavioural risk factors. Designed to assist CCGs to develop their commissioning intentions
Local Commissioning Intentions	Commissioning priorities/intentions of each of the Clinical Commissioning Groups and Surrey County Council
East Surrey CCG System Transformation Programme	Describes the projects and pathway transformation programmes across the health and social care system
East Surrey CCG DLIG Dementia Pathway	The Surrey Dementia strategy sets out a plan to achieve national dementia targets through a whole systems approach (health, social care and third sector)
Guildford and Waverley CCG Primary Care	This describes a model for the operational

Plus+ Commissioning Plan	integration of services with Primary Care
Guildford and Waverley CCG Urgent Care Strategy	This describes the future system of access urgent care including A&E
Surrey Downs CCG Out of Hospital Strategy	This strategy focuses on plans to increase investment in community services in Surrey Downs so that more people can receive care closer to their own homes
North East Hampshire & Farnham CCG System Transformation Programme	Transformation Programme across the Frimley System in collaboration with NHS Surrey Heath CCG and NHS Bracknell & Ascot CCG
North East Hampshire & Farnham CCG 5 Year Vision	Vision and commissioning strategy for 2014 to 2019
Report on North East Hampshire & Farnham CCG Stakeholder Event	Feedback from local stakeholder event demonstrating influence on joint Better Care Fund plans
Frimley System Dementia Strategy & Frimley DLIG Dementia Pathway	System wide dementia strategy and pathway to improve outcomes for the population
North East Hampshire & Farnham CCG Vision for Primary Care	System wide vision for the involvement and development of Primary Care services
NHS NW Surrey CCG Strategic Commissioning plan	The strategic direction for NW Surrey for the next five years. Five main programmes of Acute care, Frailty, Children and young people, Planned care, Mental Health and Learning Disability, Targeted communities
NHS North West Surrey CCG Expression of Interest for Seven Day Service Improvement Programme	A submission to the DH to become a pilot site developing seven day services for the Integrated Frail Elderly Urgent Care Pathway

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

7

The vision for health and social care services for Surrey for 2018/19 is:

"Through mutual trust, strong leadership and shared values we will improve the health and wellbeing of Surrey people"

This will mean:

- Innovative, quality driven, cost effective and sustainable health and social care is in place
- People keep as healthy and independent as possible in their own homes with choice and control over their lives, health and social care support
- We support and encourage delivery of integrated primary care, community health and social care services at scale and pace

Our shared values are:

- Respect and dignity - We value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we are able to do.
- Commitment to quality of care - We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.
- Compassion - We respond with kindness and care to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering.
- Improving lives - We strive to improve health, well-being, and people's experiences of our services.
- Working together for people and their carers - We put people first in everything we do. We put the needs of our communities before organisational boundaries.
- Everyone counts - We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind.

The changes that will have been delivered in the pattern and configuration of services over the next five years in Surrey will be to:

- Have fully developed out of hospital care, including early intervention, admission avoidance and early hospital discharge through:
  - Engagement with providers
  - Co-design and co-delivery with patients, service users and the public
  - Investment in social care and other local authority services

- Investment in primary care
- Investment in community health services

- Have effective arrangements for integrated working with shared staff, information, finances and risk management
- Have accountable lead professionals across health and social care, with a joint process to assess risk, plan and co-ordinate care
- Deliver 7-day health and social care services
- Use new technologies to give people more control of their care
- Dementia friendly communities that support people to live in their own community

Delivering this vision will make a difference to patient and service user outcomes. It will mean people in Surrey will:

- Be able to stay healthier and independent for longer with choice and control over their lives and indeed where they die
- Know they will only be admitted to a hospital if there is no other way of getting the care and support they need
- Be supported to return home from hospital as soon as possible and will be able to access care and support to help get them back on their feet
- Know about and be able to access information, care and support in their local community to keep them at home
- Experience health and social care services which are joined up
- Receive a consistent level of care and support 7-days a week
- Remain safe
- Be happy with the quality of their care and support, no matter who delivers it
- Be part of their local community

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b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We have to meet the needs of a growing population of frail elderly residents and people with long term conditions in Surrey, taking into account the aspiration of high quality care closer to home. The existing model of care is predominantly acute hospital based. This has occurred largely because primary and community providers haven't operated as an effective network to support people in a timely way without resorting to hospital provision.

The existing model of health and social care cannot continue to cope with the projected demand for services nor fund that additional activity. Individual organisations may be able to protect their budgets and income streams temporarily, whilst instigating cost reduction programmes but if the health and social care economy is in deficit, then inevitably so will be all its constituent members.

The alternative and preferred option for local partners is to fundamentally transform the care system, to deliver high quality, timely interventions within the community or in hospital to support a greater proportion of people to remain within their own homes. This

transformation cannot be achieved within a system of competition between agencies but requires more than simple co-operation.

Our aim is for health and social care agencies to work in partnership, to create an enhanced and integrated model of community based health and social care that improves outcomes for Surrey residents.

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Our over-arching objectives will be to ensure we:

- Help vulnerable people to be as independent as possible
- Help people avoid going into hospital unnecessarily
- Enable people to leave hospital once they are medically fit
- Prevent people having to move into a nursing or residential home until they really need to

We will measure these aims and objectives by using the social care, public health and NHS outcomes frameworks to establish a joint dashboard of measures most relevant to our aspirations for our local population, including the national Better Care Fund measures.

The measures of health gain we will apply to the Surrey population will be to:

- Prevent people from dying prematurely, with an increase in life expectancy for all sections of society
- Make sure those people with long-term conditions including those with mental illnesses get the best possible quality of life
- Ensure patients are able to recover quickly and successfully from episodes of ill-health or following an injury
- Ensure patients have a great experience of all their care and support
- Ensure that patients in our care are kept safe and protected from all avoidable harm
- Prevent people from dying prematurely and decreasing potential years of life lost from causes considered amenable to healthcare

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Each of the Local Joint Commissioning Groups in Surrey have developed a local joint health and social care work programme to deliver the over-arching vision, aims and objectives set out in the Surrey Better Care Fund Plan. The decision to develop local joint work programmes was designed to enable each area to address the needs of their specific communities, the different histories, patterns of service provision, service providers, strengths, needs as identified in the Joint Strategic Needs Assessment and challenges, as well as the need for local ownership and leadership.

The following provides an overview of key themes from each of the six local joint work programmes and gives examples of how the enhanced and integrated model of community based health and social care in Surrey will deliver better health, outcomes and experience for the population.

1. **Transformed prevention and early intervention for people at risk of becoming unable to manage their health and social care needs**

   The local joint commissioning work programmes will deliver this by, for example:

   - Recognising the connections individuals have with their family, friends and local community networks, to support them to stay healthy, independent and to manage their own care
   - Improving the networks of provision and coordination of practical preventative support services with district and borough councils, the voluntary sector and carers organisations
   - Offering universal advice and information services to all local people to promote their independence and wellbeing
   - Increasing support for health and social care self management and self care supported by the community delivery of specialist health services
   - Creating dementia friendly communities

2. **Enhanced, integrated primary and community based care delivering equivalence in the out of hospital environment and ensuring practitioners and the public have as much confidence in out of hospital services as hospital care**

   The local joint commissioning work programmes will deliver this by, for example:

   - Establishing local integrated community teams organising around GP practice populations, either individually or in networks. This would include GPs, geriatricians, therapies, community health services, mental health services, social care, reablement, district and borough services and the voluntary sector
   - Enhancing primary care services operating in networks of practices providing systematic medical leadership seven-days a week, including a review of out of

hours services

- Redesigning an integrated frailty pathway, incorporating end of life, ensuring older and vulnerable people receive proactive support to keep them independent and well in their own home, and responsive care that delivers timely interventions to avoid the need for urgent or emergency care
- Continuing the focus on developing more integrated support for people with dementia and their carers, with for example the introduction of community based geriatricians and psycho-geriatricians to support elderly people with dementia
- Implementing a lead professional role for those people who are over 75 or most at risk of a hospital admission
- Providing a single patient centred care plan, which is electronically accessible to all relevant health and social care professionals

3. Comprehensive community based services offering safe, excellent and effective alternatives to hospital admission, available seven days a week

The local joint commissioning work programmes will deliver this by, for example:

- Expanding provision of joint community based rehabilitation and reablement to help people recovering from an illness or set back (including post-stroke)
- Encouraging effective residential/nursing care home and home based care support to enable the independent sector to contribute to the effectiveness of the whole system and address admissions to acute care from these settings
- Enhancing social care and specialist health services
- Ensuring effective urgent or emergency response services, including an urgent home assessment and treatment service (in partnership with the ambulance service), access to short stay beds and respite services, carers support in crisis, delivery of Keogh clinical standards for urgent and emergency care
- Providing seven-day, 24-hour services where needed to optimise the urgent care pathway
- Creating effective arrangements for continuing health care assessment and placement, including improving patient experience and outcomes, with for example discharge to assess beds, joint health and social care assessments
- Focus on supporting people with dementia to live at home for as long as they choose

4. Excellent hospital care delivering the very best care to those individuals with the most acute, specialist or complex needs and a discharge system that enables people to return home earlier in their recovery pathway

The local joint commissioning work programmes will deliver this by, for example:

- Working with all agencies to achieve access to services seven days a week to support timely discharge from hospital once the acute phase of an individual's illness has passed
- Ensuring greater integration of services in A&E, including psychiatric liaison, to support admission avoidance, so only those patients whose needs cannot be met safely in the community are admitted to hospital
- Establishing an integrated discharge network/model across services including rapid response, occupational therapy, reablement, telecare, home from hospital, equipment, transport etc

Other programmes will focus upon the key enablers and will include for example:

- Systems leadership and joint local management, including programme and project management
- Development of personal health budgets and direct payments to promote patient independence with flexible tailored healthcare
- Provision of community equipment
- Developing a Surrey health and social care workforce strategy and plan to ensure 'skills for care', leadership development, sufficient capacity and flexibility to meet future demand and a culture of innovation that supports new ideas and creativity
- Optimisation of new / existing technologies to give people more control of their care
- Systems development and the introduction of systems which talk to each other

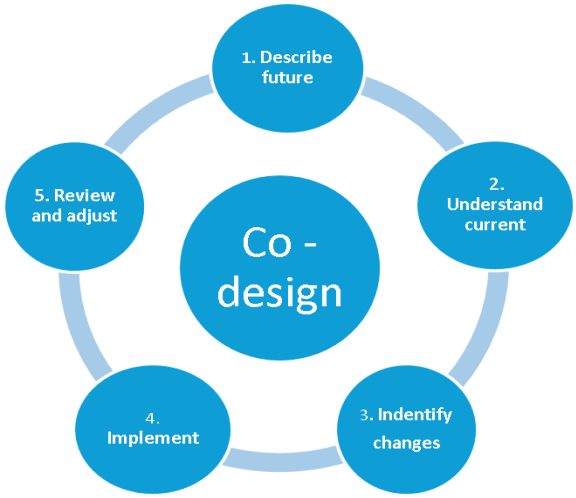
The County Council will take a co-design approach to ensure Surrey is ready to meet new duties under the Care Bill. This will include:

- Designing and implementing care accounts for self-funders.
- Providing a public facing portal so residents can understand how best to meet their support needs and to progress towards the cap.
- Reviewing support offered to carers, particularly young carers, to enable them to sustain their caring role.
- Reviewing how we assess eligibility to incorporate a 'strength based approach'
- Reviewing Surrey's information, advice and advocacy strategies

The key success factors will be:

- Reduction in the number of emergency admissions, including admissions from nursing and residential homes
- Reduction in the number of delayed transfers of care at the five acute hospitals
- Improved patient and service user experience including:
  - People having the advice and information to make informed choices
  - More people with long term conditions feeling supported to manage their care
- Reduction in the average length of stay in nursing and residential care

The process for delivering the joint work programme across Surrey will be managed at a local level through the Local Joint Commissioning Groups. These groups will adopt a programme/project management approach and will use models, such as that below:



The following principles will underpin the process for delivering the joint work programme across Surrey delivery:

- Co-design and co-delivery with patients, service users and the public
- Being courageous and providing the leadership necessary to make change happen
- Continuing to deliver good quality health and social care services whilst we make changes
- Changing our relationships to true partnership with a culture of innovation and learning
- Building upon best practice and utilising work already undertaken
- Working collaboratively with other Local Joint Commissioning Groups where services operate across boundaries and where providers are co-commissioned

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The anticipated time frames for delivery are proposed as:

Q4 13/14
- Define future states "end states" - co-design workshop
- Begin to collate information on best practice and current services from existing sources. Increased shared understanding
- Refine local BCF plans with detailed modelling and cost benefit analysis

Q1 14/15
- Co-design workshops to describe existing services, systems and processes from a number of perspectives & key areas for change against future state
- Develop shadow arrangement for local budgets and local performance outcomes to prepare for full BCF implementation

Q2 14/15
- Implement any quick wins identifed above
- Detailed work with providers finalised specifics of changes required and provider impact

Q3 14/15
- Develop transition plan and contract strategy to deliver required changes from April 2015 to enable release of any core health funding
- Put systems in place to baseline outcome measures

Q4 14/15
- Agree implementation process with providers and put enables in place to "go live" from 1 April 2015. Implement transition plan
- Communicate proposed changes to local population & all key stakeholders

Q1 15/16
- Fully implement pooled budgets and assoicated services
- Review outcomes and adjust

Q2 15/16
- Identify planned changes for 16/17

Q3 15/16
- Develop transition plan and contract strategy to deliver required changes from April 2016

Q4 15/16
- Agree implementation process with providers and put enables in place to "go live" from 1 April 2016. Implement transition plan
- Communicate proposed changes to local population & all key stakeholders

7

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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At this stage we are still working with stakeholders to complete the modelling required to clarify implications of our strategic plans on providers, particularly the acute hospitals.

We are clear, however, that our focus to reduce pressure in the urgent care pathway and to create an enhanced and integrated model of community based health and social care, will ensure activity risk is better balanced across the system, thereby reducing demand on the acute sector. Finalisation and delivery of our Better Care Fund plan will be based upon a whole system partnership. In financial, workforce and resource terms, it is this partnership that will model and work through implications on all parts of the system, ensuring risk is shared and effectively managed.

If savings are not realised in the acute sector once investment in community services is made, there is a risk that disinvestment in some areas of healthcare would be required, with risk sharing arrangements to be agreed. Contingency plans will need to be in place based upon a number of scenarios as outlined in the Risks section below.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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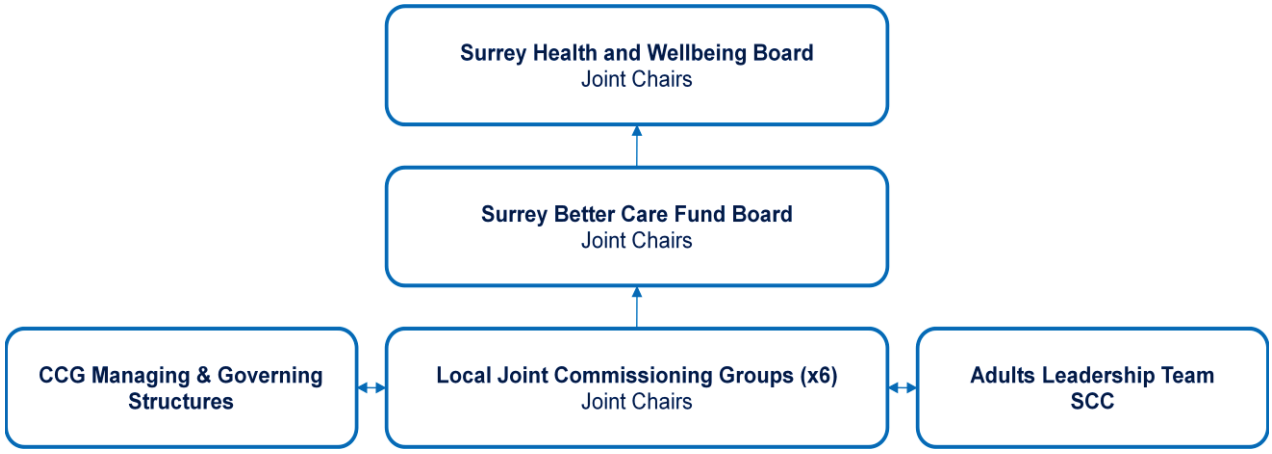
The governance arrangements in place for oversight and governance of progress and outcomes are as follows:

- There are six Local Joint Commissioning Groups in Surrey – one for each of the six local CCG areas - with membership drawn from Adult Social Care, the CCG and other local stakeholders, including district and borough councils, patient/service user and carer representatives.
- The Local Joint Commissioning Groups will be responsible for all Better Care Fund investment decisions. These investment decisions will be made jointly by health and social care partners at a local level.
- The Local Joint Commissioning Groups will be responsible for overseeing the operational delivery of the schemes set out in their local joint work programme and for delivering the radical transformation needed in their local area to provide better care in the future.
- The Surrey Better Care Fund Board will provide strategic leadership across the Surrey health and social care system and hold the Local Joint Commissioning Groups to account for how they invest the Better Care Fund and the progress and outcomes they deliver.
- Surrey's Health and Wellbeing Board will continue to set the overarching strategy across the Surrey health and social care system.
- There will be clear financial governance arrangements agreed and put in place for the management of the Better Care Fund pooled health and social care budget.



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

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We aim to sustain the universal and preventative services which are not statutory and so might have be reduced if there are budget shortfalls, and to contribute towards the future additional cost of demographic growth, ie those future commitments which might have to be 'managed down', for example by changes to eligibility criteria, if social care budgets are not sustained.

Please explain how local social care services will be protected within your plans

The system across Surrey has committed to jointly investing the Better Care Fund to improve services and outcomes for patients and to creating financial benefit as a result. We have agreed to share this benefit for further investment in services and to ensure the sustainable delivery of better care for the future. In 2015/16 we expect the benefit to social care to be £25m.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There is a clear commitment to commissioning seven-day services across Surrey amongst health and social care partners, so that the system is able to provide sufficient capacity to meet demand across the urgent care pathway, to support discharge and prevent unnecessary admissions at weekends. This is in line with Keogh clinical standards and Royal College guidelines.

Progress has already been made, with for example:

- Adult social care staff working from 8.00am - 8.00pm Monday to Friday, 9.00am - 5.00pm Saturday and Sunday in all five of Surrey's acute hospitals, since October 2012
- Adult Social Care is developing a Market Position Statement to signal requirements to the wider market. This will also include a refresh of commissioning strategies, specifications and terms and condition to ensure that the whole system, including the independent social care sector is aligned to the seven-day service objective
- Outline plans are in place for the integration of health and social care teams around practice populations as part of 'Primary Care Plus' in Guildford and Waverley CCG, to operate 7-days per week with extended hours to 8.00pm
- North West Surrey CCG's model of urgent care and community service provision which will deliver services in the community through 3 community hubs, integrated primary and community care provision 7-days per week

The commitment to seven-day services underpins all the schemes and changes set out

in the Surrey Better Care Fund. This commitment will be taken forward as part of Surrey's work to shape the new integrated model of community based health and social care. The next steps will be to:

- Analyse demand against capacity in the urgent care pathway - this will include for example, primary care (including GP out of hours services), psychiatric liaison services, pharmacy, crisis management intermediate care and reablement, hospital discharge services, and the capacity of home care providers, nursing and residential care homes to accept new referrals across seven days
- Engage with patients, service users and frontline staff across all agencies to understand the opportunities, challenges and desired outcomes, ensuring that solutions are co-designed and co-delivered
- Understand the capacity in existing contracts and how this can be maximised
- Make local joint investment decisions that deliver the required changes

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c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

DH Gateway Ref 17742 defines how the NHS Number must be used in identifying people receiving health and care services. The standard sets out how information systems must accept, store, process, display and transmit the NHS Number (which is deemed patient confidential data). In accordance to these changes, CCGs will continue to ensure that all provider organisations use the NHS number as the primary identifier as part of their commissioned services. With respect to commissioning and planning purposes, NHS numbers or any other patient identifiable data will not be used unless consent is given. Where correspondence is required across health and social care services to enable direct care for an individual, NHS numbers will be one of the identifiers used where appropriate.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Adult Social Care are currently testing the load of the NHS number into the Adults Integrated System (AIS) and expect the NHS number to be live by mid-February 2014.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All partners in Surrey are committed to sharing information effectively within the guidance to provide integrated services. Effectively collecting, sharing and interpreting data is fundamental to the transformation we need to deliver. We are committed to adopting systems that are based upon Open APIs and Open Standards. This includes ensuring that we use secure e-mail standards and adopt locally agreed interoperability standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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The CCGs ensure all provider organisations use the NHS number as the primary identifier as part of their commissioning of services and that Information Governance is included within their Statements of Internal Control and as part of the NHS Standard Contract. Each contract references and adheres to IG controls. All Information Flows are reviewed to ensure compliance with Caldicott2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The Local Joint Commissioning Groups are committed to the principle whereby people at high risk of hospital admission will have an accountable lead professional as part of a joint process to assess risk, plan and co-ordinate care.

x% of the adult population in Surrey has been identified as at high risk of hospital admission. The approach used to identify them was xyz and x% of individuals at risk have a joint care plan and accountable professional. Metrics group to have undertaken analysis by end February 2014

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
1. Insufficient leadership and/or operational capacity to deliver this major transformation change programme	Amber	Strong governance arrangement and the ability of partners to challenge one another constructively, honestly and openly Provide programme/project management capacity, including backfilling for operational staff as required
2. Insufficient engagement with patients, service users and the public, so future services do not meet the needs of the local community	Amber	Ensure sufficient capacity and expertise is made available to deliver a comprehensive communication and engagement plan
3. Scheduling of change is complex with risk of potential gaps if acute services are reduced before community capacity is in place	Red	Transition planning and co-design critical. Close project management and pre-planned decommissioning schedules to underpin plan
4. Provider market in health and social care is insufficiently developed to support the future services required in the community	Red	Develop market management strategy to support the local joint work programmes across Surrey
5. Unplanned activity - A&E attendance and non-elective admissions - do not reduce at the level or pace required	Amber	Analyse required changes, joint planning and management of acute sector bed capacity reduction
6. Level and pace of discharge from hospital does not increase as required	Amber	Establish an integrated discharge network/model across services
7. Agencies are unable to change relationships, culture and behaviours	Amber	Strong leadership from the Surrey Better Care Fund Board Programme of change management interventions to support service transformation
8. Lack of improvement in the continuing healthcare process as part	Amber	Implement the programme of change arising from the recent review of continuing

of the overall discharge pathway		healthcare
9. Costs of the new system in health and social care exceeds return	Amber	Robust financial management arrangements are put in place
10. Improvement is not demonstrated against national and local metrics and performance element of the Better Care Fund is not secured	Amber	Ensure sufficient capacity and robust arrangements to monitor and report against national and local metrics as part of the governance arrangements
11. People with dementia are left unsupported	Amber	Ensure best whole systems approach to care

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget (for 2014/15)? (Y/N)	Spending on BCF schemes in 14/15** £'000	Minimum contribution (15/16) £'000	Actual contribution (15/16) '£000
Surrey County Council*	Y	*4,000.000*	*5,327.378*	*5,327.378*
NHS East Surrey CCG	N		*9,397.000*	*9,397.000*
NHS Guildford & Waverley	N		*11,246.000*	*11,246.000*
NHS North West Surrey CCG	N		*19,808.000*	*19,808.000*
NHS Surrey Heath CCG	N		*5,501.000*	*5,501.000*
NHS Surrey Downs CCG	N		*16,398.000*	*16,398.000*
NHS North East Hampshire and Farnham CCG	N		*2,609.000*	*2,609.000*
CCG	N		*532.000*	*532.000*
BCF Total		**4,000.000**	**70,818.378**	**70,818.378**

** Assumes SCC will be fundholder for all BCF projects in 2014-15. 2015-16 SCC allocation is indicative for both the PSS capital Allocations and DFG.*

*** Based on additional funding within Section 256 allocation*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16 £m	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Title	Lead provider	Description	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
				Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
ES01	High Level Schemes to Transform Out of Hospital Care		Continuing Health Care -evaluation and redesign of current continuing health care programme								
			Pre A&E and A & E Front Door								
			Effective Stroke System Pathway including Stroke Community Rehabilitation								
			Sub-acute Pathway established as the "norm"								
			Frail Elderly								
			Mental Health (including adults and children, dementia pathway and Psychiatric Liaison service)								
			End of Life Care								
			Integrated Discharge Model								
			Prevention Programmes including Telehealth and Telecare.								
ES02	Projects to Support Transformation Schemes		Asset Based Community Development: Taking stock of total health and care asset base to maximise capacity. (e.g.Residential Care Bed Availability, Discharge to Assess, Discharge hotel)								
			Risk Stratification								
			Integrated Virtual Wards: Part of the local community health pathways.								
			Hospital Staffing: The 8-8 M-F and weekend working of social care staff in acute hospitals								
			Reablement Staffing: Timely discharge and increased dependency in communities.								
			Red Cross: Supports reduction in inappropriate admissions.								
			Development of Integrated Night Response Service								
			Therapy Intervention: Therapy to support bed based reablement in SCC's OP residential homes.								
			Community Equipment: Supports the virtual ward and encouraged the use of single-handed hoists.								
			Occupational Therapy: Funds the social care OTs in the reablement teams.								
			Sourcing Staffing: Funds the social care sourcing team.								
			Universal Benefit Service: Welfare benefits advice to vulnerable adults.								
			District & Borough: Funds the PPP community development services in district and boroughs.								
			Personal Health Budget Implementation: To embed and support on-going monitoring and evaluation in 2014/15								
ES03	Actions to Support and Enable Integration		Integrated Workforce Planning and Infrastructure Development (includes reviewing job descriptions, training and development, culture change, information management and communications etc)								
			Engagement and Communication Planning								
			Programme and project management support.								
ES Total											
GW01	Rapid Response										
GW02	Primary Care Plus +										
GW03	Telecare										
GW04	Virtual Ward										
GW05	Mental Health										
GW06	Other										
GW Total											
SD01	An enhanced, developed primary care service operating in networks of practices		Establish a Community Medical Network								
			Commission local General Practice to review vulnerable patients								
			Increase GP capacity								
			Commission specialist clinical networks								
			Implement risk stratification of practice lists								
SD02	Ensure improved patient experience and outcomes within the continuing care assessment process through		Joint health and social care assessments								
			Streamline the healthcare assessment tool								
			'Discharge to assess'								
			Pilot Local Authority Community Development Officers								
			Enable acute hospitals to undertake CHC placements								
			Equipment								
SD03	An Urgent Care and Discharge System that works to enable people to return home earlier in their recovery pathway		Urgent care								
			Ambulatory care								
			7 day integrated working								
			Early Discharge								
			Intermediate beds								
			Practical support services								
			Development of End of Life provision								
			Community Transport								
SD04	Facilitate rapid discharge for those people with high risk of hospitalisation through		Establish 5 Integrated Community Teams								
			Rehabilitation at home								
			Reablement								
			Working in partnership								
SD05	Integrated services to reduce admission (Enhanced Case Management)		MDT working								
			Information Sharing								
			Medicines management								
SD Total											
SH01	Admission Advoidance		Care Planning								
			Care Recording								
			Community Resilence								
			Crisis Management								
			In reach services								

SH02	Rapid Discharge		Discharge Planning									
			Early Supported discharge									
			CHC (community health care) assessment & placement									
SH03	Nursing/residential home support		Care planning									
			Nursing leadership, skills and competencies									
			Transfer to and from homes and other care providers									
SH04	Rehabilitation and Re-ablement		Rehabilitative services									
			Re-ablement services									
SH05	Enabling services/structures		Information sharing/IG									
			Tele-care									
			Tele-health									
			Risk stratification									
			Strategic workforce planning									
SH Total												
NEHF01	A significantly greater investment in prevention and in earlier intervention for those at risk of		Systematically identify those at higher risk, intervene earlier to manage that risk.									
			Provide more support for patients and their carers, by harnessing the potential of the third sector									
			Test how we offer Personal Health Budgets (PHB) to patients who are eligible for Continuing Health Care (CHC).									
NEHF02	A new model of integrated primary and community care		Design local integrated Care Teams to include GP Practices, Community Services, Mental Health Service, Social Care and the Voluntary Sector.									
			Trial the production of Personal Care Plans in the Integrated Care Teams Pilot.									
			Redesign services for frail elderly people who require support to remain at home.									
			Provide step up and step down beds in Farnham to integrate reablement and intermediate care									
			New integrated services to support patients at the end of life and their families and carers									
NEHF03	A comprehensive range of community based services offering safe, excellent		Deliver greater levels of community based rehabilitation and reablement in order to break the vicious circle of admission, discharge and readmission.									
			Improvements for residents to ensure they receive the correct nutrition and hydration to prevent ill health.									
NEHF04	Excellent hospital care focussed on delivering the very best care to those individuals with the most acute		Work in partnership with all agencies to achieve access to services across 7 working days									
			Transformation of community services and through greater integration of services in A&E, that only those patients whose needs cannot be safely met in the community, are admitted to hospital									
NEFH Total												
NW01	Integrated Frailty Pathway (incorporating end of life)		Ensuring older and more vulnerable people receive (i) proactive support to keep them independent and well in their own place of residence and (ii) responsive care that delivers timely interventions when required to avoid the need for urgent or emergency care. We will deliver an integrated pathway through									
			Implementing a lead professional role for those people who are over 75 or most at risk of a hospital admission									
			Providing a single patient centred care plan, which is electronically accessible to all relevant health and care professionals									
			boroughs/districts									
			Continued focus on developing more integrated support for people with dementia and their carers									
			Joint delivery of reablement services for those recently discharged from hospital (including post-stroke)									
			Review of the rehabilitation pathway, including effective utilisation of rehabilitation beds									
			A joint approach to the support and development of nursing/care homes									
			Optimisation of technology where appropriate									
			An integrated approach to the procurement of continuing healthcare									
NW02	Integrated Urgent Care Pathway		Ensuring an effective and timely response when people need an urgent or emergency service, that flow through the whole system is optimised at all times, and that people are returned to their normal place of residence, with appropriate support where required, as quickly as effective care allows. We will streamline urgent and emergency services by investing									
			A 'telephone first' approach through creation of a single telephone hub with direct co-ordination and booking access to all urgent care services including same-day primary care.									
			An urgent home assessment and treatment service (in partnership with the ambulance service)									
			A review of walk-in clinics and out of hours services with potential development of a co-located urgent care centre at St Peters Hospital									
			Access to short stay beds and respite services to prevent unnecessary hospital admission									
			Delivery of Keogh clinical standards for urgent and emergency care									
NW03	Integrated Locality Hubs		Focused on delivering equivalence in the out of hospital environment and ensuring both care practitioners and the public have as much confidence in out of hospital services as in hospital care. Over the next five years our ambition is to invert care provision so that significantly more of our resources are invested proportionately in the out of hospital environment as opposed to on hospital care, for example through developing									
			Aligned services in three locality hubs (primary care, community services, social care, ambulance services, third sector care etc.), led by GPs									
			Systematic medical leadership 7 days a week, provided by primary care (including a review of out of hours services)									
			Enhanced social care and specialist health services									
			Named care co-ordinators for the elderly and vulnerable, ensuring continuity of care for those who need it most									
			7 day, 24 hour services where needed to enable the urgent care pathway									
			Extended access to planned care services including better integrated pathways that optimise outcomes for patients									
NW Total												
Grand Total												

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

A joint metrics group has been established. The group will undertake the analysis needed to define the expected outcomes and benefits by end of February 2014.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Surrey has agreed to use the national metric which is currently under development.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

A Joint metrics group has been established and will develop a response by end of February 2014.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Surrey is planning with the Surrey Health and Wellbeing Board only and will thus submit a single Surrey-wide version of the metric template.

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Comments
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	567.7	N/A		Data extracted from HSC IC (2010/11-2012/13) This is not available in the Operational Planning Atlas as stated in the Guidance
	Numerator	1,155			
	Denominator	203,275			
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72	N/A		Data extracted from HSC IC (2010/11-2012/13) This is not available in the Operational Planning Atlas as stated in the Guidance
	Numerator	225			
	Denominator	315			
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	198.8			Data extracted from NHS England published statistics, Delayed Transfer of Care
	Numerator	27,668			
	Denominator	139			
		(Dec 2012 - Nov 2013)	(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure)	*Metric Value*				**See Comments data sheet** Data is available at CCG level (2009/10- 2012/13) One of the 4 indicators which maske up this composite is available at LA level (2003/04 - 2012/13 This data is available on the Ambitions Atlas
	Numerator				
	Denominator				
		(TBC)	(April - September 2014)	(October 2014 - March 2015)	
Patient / service user experience [National metric (under development) is to be used]			N/A		Await National Metric
Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	*Metric Value*	43.90%			Based on Dementia Calculator Check indicator and also may be able to update to 2012/13 data?
	Numerator	6872			
	Denominator	15669			
		(April 2011 - Mar 2012)	*(insert time period)*	*(insert time period)*	

Details of how the £65.5m will be invested, and the stretch targets and financial outcomes associated with the investments, are the subject of ongoing joint planning between the County Council and Surrey's CCGs. Those plans will be reflected in the April submission

Health and Wellbeing Board
6 February 2014

Allocation and Drawdown of Whole Systems Funding (Social Care Transfer from NHS to Surrey County Council)

Purpose of the report: To approve the drawdown and distribution of the NHS England allocation of Whole Systems Funding to Surrey County Council

This report shows how the money is planned to be used and the agreed monitoring arrangements. Appendix A is the draft Section 256 agreement covering the transfer of the funds between Surrey County Council and NHS England.

Introduction:

1. On 19 December 2012, the Department of Health wrote to the NHS Commissioning Board (DH Gateway reference 18568) setting out the allocations and details of the Funding Transfer from NHS to Social Care 2013-14. The letter suggested Health & Wellbeing boards as a natural place for discussion of the use of the funding. Subsequent guidance from NHS England (Gateway reference 00186) received on 19 June 2013 states that the Health & Wellbeing Board must receive a joint report from the Clinical Commissioning Group and Local Authorities to agree use of the funding, the measured outcomes and the agreed monitoring arrangements.

2. Guidance from NHS England about the funding transfer states that:
   2.1 'The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.'
   2.2 The guidance goes on to state that:
   The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system. NHS England will ensure that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be

the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.'

3. In Surrey, joint governance arrangements have been long established, through a Whole Systems Board of commissioning representatives from both Health and Social Care.

Allocation of the 2013-14 Whole Systems Funding

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4. For 2013-14 the Whole Systems Funding being transferred to Surrey County Council is **£14,297,472**

Allocation of the funding into projects and activities is agreed through the joint Whole Systems Funding Board. Plans are jointly monitored through this Board, approving any operational reallocation of funds across priority areas. It has been agreed between the Council and the CCGs that any moneys not spent on the identified projects within 2013/14 will be reallocated to the following joint priorities with whole system benefits:

• Joint Equipment budget (ICES) any overspend due to increases in demand	c£500k expected
• End of Life contract extension	£144k
• HIV Terrance Higgins Trust	£310k
	£954k

Any underspends not covered by those agreements for specific use will be split 50:50 between SCC and the CCGs, to contribute towards spending with Whole System benefits.

5. Reporting has been defined into NHS priority areas:

- Community equipment and adaptations
- Telecare
- Integrated crisis and rapid response services
- Maintaining eligibility criteria
- Re-ablement services
- Bed-based intermediate care services
- Early supported hospital discharge schemes
- Mental health services
- Other preventative services
- Other social care (please specify)

6. Appendix B details the individual financial allocation to each project within these priority areas. This schedule was approved by the representatives of the Whole Systems Funding Board at a joint workshop held on the 14th November 2013.

Conclusions:

7. The Whole Systems Funding is being used appropriately within the framework established by Health England. Priorities and projects have been jointly approved between Health and Social Care Commissioners.

Recommendations:

8. The Board is recommended to approve the allocation of the Whole Systems Funding into the individual projects and NHS priority areas, enabling this funding to be drawn down from NHS England.

Next steps:

Once approved by the Board, we anticipate that the Sec256 agreement will be signed by Health England, enabling Surrey County Council to draw down the funds.

A final report will be provided to the board detail the distribution of funding including eligible expenditure funded through the unallocated funding.

Report contact: Neill Moore, Senior Principal Accountant (Projects), Adult Social Care Finance Team.

Contact details: Email: neill.moore@surreycc.gov.uk, telephone 07971 664941

Sources/background papers:

- DH Gateway reference 18568
- Gateway reference 00186

Appendix B

Whole Systems Funding allocation by project as at November 2013

Proposed Funding Allocation by Activity		
ACTIVITY		TOTAL ALLOCATED FUNDING 2013-14
Community Equipment and Adaptations		
14	Community Equipment	200,000
22	Adaptions managed at District & Borough level	1,000,000
Telecare		
1	Telecare	1,891,500
2	Telehealth	1,412,800
Integrated Crisis and Rapid Response Services		
6	Integrated Virtual Wards	1,654,999
Maintaining Eligibility Criterior		
26	Personal Health Budget Implementation	150,000
Re-ablement Services		
9	Reablement Staffing	1,348,237
Bed Based Intermediate Care Services		
8	Hospital Staffing	994,275
Early Supported Hospital Discharge Schemes		
11	Development of Integrated Night Response Service	107,838
17	Sourcing Staffing	108,523
Other Preventative Services		
3	Risk Stratification Tool	112,000
12	Therapy Intervention	584,551
16	Occupational Therapy	623,539
Other Social Care Services		
10a	Red Cross	274,999
10b	Stroke Support	115,600
20	End of Life	606,611
21	Universal Benefit Service	500,000
Mental Health Services		
19 & 23	Mental Health - SDS and Community Connections	669,261
15	Mental Health - Dementia	1,685,000
	SUB TOTAL ALLOCATED AS AT NOV13:	14,039,733

UNALLOCATED FUNDING		TOTAL UNALLOCATED
		257,739
	UNALLOCATED AS AT NOVEMBER 13:	257,739