Notice of Meeting

Health and Wellbeing Board

Date & time
Thursday, 3 April 2014
at **1.00 pm**

Place
Council Chamber, Woking Borough Council, Civic Offices,Gloucester Square, Woking, GU21 6YL

Contact
Huma Younis
Room 122, County Hall
Tel 020 8213 2725
huma.younis@surreycc.gov.uk

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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 for Children, Schools and Families
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
Dave Sargeant	Interim Director for Adult Social Care
Peter Gordon	Healthwatch Surrey
Mr Mel Few	Cabinet Member for Adult Social Care

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: 13 MARCH 2014 (Pages 1 - 8)

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

4a Members' Questions

The deadline for Member's questions is 12pm four working days before the meeting *(Friday 28 March 2014).*

4b Public Questions

The deadline for public questions is seven days before the meeting (*Thursday 27 March 2014)*.

4c Petitions

The deadline for petitions was 14 days before the meeting. No petitions have been received.

5 FORWARD WORK PROGRAMME (Pages 9 - 10)

To consider the Board's Forward Work Programme and confirm the agenda for the next meeting on 5 June 2014.

6 BOARD APPROVALS (Pages 11 - 12)

For the Board to receive any approvals for sign off.
The Board has been asked to endorse the Draft Safeguarding Protocol.

7 JHWS PRIORITY: OLDER ADULTS HEALTH & WELLBEING PRIORITY (Pages 13 - 28)

This report provides an update on the work that has been undertaken to develop the Health and Wellbeing Board's action plan for the 'Improving older adults' health and wellbeing' priority – it sets out the rationale for the priority (the evidence base), describes what the work is trying to achieve and also how it will be achieved.

8 SURREY-WIDE BETTER CARE FUND: SIGN OFF (Pages 29 - 74)

The Health and Wellbeing Board is asked to review and sign off the 'final' Surrey-wide Better Care Fund and submit to NHS England by 4 April 2014 deadline.

9 PUBLIC ENGAGEMENT SESSION

A presentation will be delivered on the county draft alcohol strategy which forms a section of Surrey's Substance Misuse Strategy.

An opportunity for the public to ask the Board any questions arising from the items discussed at the meeting.

David McNulty
Chief Executive
Surrey County Council
Published: Wednesday, 26 March 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.

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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 13 March 2014 at Old Council Chamber, Reigate & Banstead Borough Council, Town Hall, Castlefield Road, Reigate, RH2 0SH.

These minutes are subject to confirmation by the Board at its meeting on Thursday 3 April 2014.

Board Members:

* Mr Michael Gosling (Co-Chairman, in the Chair for items 10-15, 19 & 20)
* Dr Joe McGilligan (Co-Chairman, in the Chair for items 16-18)
* Mrs Mary Angell
* Helen Atkinson
* Dr Andy Brooks
* Dr David Eyre-Brook
* Mr Mel Few
* Dr Claire Fuller
* Dr Liz Lawn
* Dr Andy Whitfield

Dr Jane Dempster

* Nick Wilson
* Councillor James Friend

John Jory
Councillor Joan Spiers
Chief Constable Lynne Owens

* Dave Sargeant

Peter Gordon

10/14 APOLOGIES FOR ABSENCE [Item 1]

Apologies for absence had been received from Mr John Jory, Cllr Joan Spiers Peter Gordon and Chief Constable Lynne Owens. Also in attendance were Ms Pennie Ford (NHS England), Mr Tom Kealey (Reigate and Banstead Borough Council) and Ms Jane Shipp (Healthwatch Surrey).

11/14 MINUTES OF PREVIOUS MEETING: 6 FEB 2014 [Item 2]

The minutes of the meeting held on 6 February 2014 were agreed and the Chairman authorised to sign them.

12/14 DECLARATIONS OF INTEREST [Item 3]

None.

13/14 QUESTIONS AND PETITIONS [Item 4]

No questions or petitions were received.

14/14 FORWARD WORK PROGRAMME [Item 5]

Key points raised during the discussion:

1. In light of the increasing list of things that the Health and Wellbeing Board is being asked to approve / take responsibility for, the Chairman advised that a list of 'responsibilities is being kept and an updated

version would be circulated to Board Members within the next few weeks.

2. The Chairman discussed arrangements for the Board to comment on CCG commissioning strategies. It was proposed that the Board discuss and agree this process at the 3rd April Board meeting with the aim of the strategies formally being discussed at the Board at the 5th June meeting.

3. The Chairman advised that alternative representatives from Board Members' organisations could attend Board meetings but would not have any voting rights.

Resolved:

The forward work programme was noted.

Actions/Next Steps:

- List of proposed items to be circulated to Board Members.
- CCG commissioning strategies to be submitted to Justin Newman as soon as they are available.

15/14 MEMBERSHIP OF THE BOARD [Item 6]

Key points raised during the discussion:

1. It had been proposed that Mr Mel Few be appointed to the Health and Wellbeing Board in his position as the Cabinet Member for Adult Social Care. This appointment would ensure similar representation arrangements on the Board for adults and children's services.

Resolved:

The appointment of the Cabinet Member for Adult Social Care to the Board be approved.

Actions/Next Steps:

None.

16/14 JHWS PRIORITY PLAN: DEVELOPING A PREVENTATIVE APPROACH [Item 7]

Key points raised during the discussion:

1. Helen Atkinson updated the Board on the progress made in turning the Prevention priority of the Joint Health and Wellbeing Strategy into an action plan. The task ahead to narrow the gaps in life expectancy within Surrey, particularly with respect to pockets of deprivation, and focus on prevention was a challenging one and so would take place in two stages. The first phase would focus on the biggest causes of ill health and early death. The second phase would widen the focus on prevention. Work was taking place between Public Health and the

Clinical Commissioning Groups on prevention plans. Work on the wider prevention agenda would be brought to the Board in the autumn.

2. The Chairman noted the importance of focusing on the impacts on people within Surrey rather than statistics. Using generalised figures and comparative data had sometimes resulted in those outside the county not always understanding the complex picture within Surrey. The vital role of the voluntary sector and the importance of continuing to actively engage with them was noted.

3. Reducing health inequalities, as set out in the Marmot review, would be dependant on working smarter and coordinating better across health, social care and the district and borough councils. This included needing to look at housing, employment, education and leisure opportunities in a joined up way. Work had already taken place, for example, to look at a prescribing approach for those groups who did not usually take up physical activity.

4. The production and ready availability of metrics on the five leading causes of health inequalities would be of key benefit to decision makers. This data could be applied when taking a wide range of decisions, for example, to determine the best locations for providing leisure facilities. Performance information on which activities proved to be effective would be vital in identifying successes and rolling them out widely and quickly. The Board expressed the desire to encourage innovation and avoid the dangers of being restricted solely to lengthy or numerous pilot and review processes.

5. An accredited 'brief interventions' training programme would be introduced and made available to both staff and those in the voluntary sector. This would help to ensure that the right conversations were taking place to enable people to be referred and supported in improving their health.

6. Opportunities to set challenging local objectives would be examined, particularly where national targets were not felt to represent an improvement for Surrey residents. This work would also examine opportunities to work with businesses, including the many national companies that were based in the county, to align objectives.

Resolved:

1. The progress made so far in turning the prevention priority into an action plan be noted.

2. The proposed approach to developing the Prevention Priority Plan, and specifically the two-staged approach, be endorsed.

3. A further update report and action plan be brought to the Board following the completion of phase two of the priority planning.

Actions/Next Steps:

None.

17/14 JHWS PRIORITY PLAN: PROGRESS REVIEW OF 'PROMOTING EMOTIONAL WELLBEING AND MENTAL HEALTH' [Item 8]

Key points raised during the discussion:

1. Diane Woods, Associate Director for Mental Health and Learning Disabilities updated the Board on the progress made against the 'Promoting Emotional Wellbeing and Mental Health' priority action plan. The Board was informed of the work that had taken place to raise awareness of mental health in order to tackle stigma and discrimination. Engagement, including increasing the availability and ease of access of information for GPs, would continue to play a key role.

2. National guidance showed that Surrey was doing quite well in this area and further clarity was expected in future around standards. Work had taken place to create a local baseline of how services were doing. This was a first step to the creation of a mental health outcomes dashboard, which would enable health and social care commissioners to measure success.

3. The engagement which had taken place so far had highlighted that services are good however this might not always be taking place in a joined up manner. The key measure of success would be that any individual who presented themselves in any manner, would have their needs assessed and met quickly, without stress and in an appropriate way.

4. Work was taking place to ensure links with the police and emergency services. This included working to the Mental Health Crisis Concordat and establishing mental health representation on the Emergency Services Collaboration Project Board.

5. The need to ensure equity of access to mental health services across the county was highlighted. Reducing the variation in levels of provision of mental health work in acute hospitals was noted as a priority area. There was also a need to ensure parity of esteem between mental health and physical health services.

6. The importance of wider factors in supporting mental health issues was noted. These included helping people with mental health issues to obtain and retain employment and issues relating to accommodation. Work would take place to ensure that mental health representatives had appropriate input to the accommodation working group between the district and borough councils and housing association representatives. High quality transition arrangements between service provision for children and adults were noted to be vital.

Resolved:

1. The progress made against actions in the Promoting Emotional Wellbeing and Mental Health Priority Plan be noted.

2. An update on the progress of the priority action plan be brought to the Board at the June meeting

Actions/Next Steps:

- Diane Woods to confirm details of dates and leads in the action plan relating to employment and accommodation (currently 'To be confirmed').
- Diane Woods to include success measures / indicators in the next update report to the Board
- Helen Atkinson to check current arrangements for representation on the accommodation working group.

18/14 JHWS PRIORITY PLAN: PROGRESS REVIEW OF 'IMPROVING CHILDREN'S HEALTH AND WELLBEING' [Item 9]

Key points raised during the discussion:

1. Nick Wilson and Dr Claire Stevens, Guildford & Waverley CCG, provided an update on the progress being made towards the Joint Health and Wellbeing Strategy priority of 'Improving children's health and wellbeing'.

2. Surrey's Health and Wellbeing Board was noted to be one of the few to have actively prioritised children and young people's health. Challenges facing Children's Services were noted to include the complex funding arrangements and the increasing day to day demand for services. All involved were determined and focused on the work taking place and what needed to be done. There was confidence that the priorities within the Strategy were the rights ones, that the right people were involved and that the work was taking place to deliver on these.

3. The Chairman congratulated Nick Wilson and his team on their passion and the advances that had been made. Board Members asked questions around aspects of the Plan including the approaches towards safeguarding, addressing substance misuse and measurements against its outcomes. A pilot was noted to be underway which placed assessment team members with police officers to triage young people within domestic abuse situations. The evaluation of this pilot was due in April and the initial view was that this was providing safeguarding at a higher and better level than before. Discussions would take place with the police and Adult Social Care regarding implementing these working arrangements more widely.

4. Board members asked when the priority plan would include how the outcomes will be measured, in order to understand the impact it is having on children, young people and families. Work is underway by officers to determine the most effective way of measuring success.

Resolved:

1. The progress towards actions to improve children's health and wellbeing be noted.

2. The approach for overseeing work through Surrey Children and Young People's Partnership and Children's Health and Wellbeing Group be noted.

3. A progress report be brought to the Board for consideration at its meeting in September 2014.

Actions/Next Steps:

None.

19/14 SELF ASSESSMENT FRAMEWORKS FOR AUTISM AND LEARNING DISABILITIES [Item 10]

Key points raised during the discussion:

1. The Health and Wellbeing Board received and considered the local Joint Health and Social Care Learning Disability Self Assessment Framework in order to inform the JSNA and Surrey Health and Wellbeing Strategy. Jo Poynter, Senior Manager for Adult Social Care Commissioning updated Board Members on the detail of the ratings and the remedial actions being taken to address red ratings.

2. Agreed actions included work to ensure that everyone in Surrey had received a care review within the past twelve months and the appointment of primary care liaison nurses to work in GP surgeries. New contracts had also been issued, following a full review of terms and conditions, for all people receiving care packages. These actions were expected to lead to green ratings next year.

3. Services for people with autism had been treated separately and were noted to be better than most. A specific Autism Partnership Board was in place to provide increased focus. It was noted that the number of people with autism being reported was increasing.

4. Ensuring appropriate support arrangements for mutual carers had received considerable focus however it was noted that some additional work could take place to identify young carers.

5. Healthwatch Surrey asked about the access liaison nurses had to GP surgeries as this had previously been highlighted as a challenge. GPs had been receptive to learning disability liaison work within their surgeries. There were currently four posts for the county and areas with higher reported levels of people with learning disabilities had been prioritised. It was noted that there were very limited numbers of people with the required expertise for working with people with learning difficulties and this presented a recruitment issue.

6. Data sharing with neighbouring areas was noted to be improving and no recent issues had been reported.

Resolved:

The continued work of the Partnership Board and the action plan going forward be noted.

Actions/Next Steps:

None.

20/14 PUBLIC ENGAGEMENT SESSION [Item 11]

1. The Board received questions from the members of the public present at the meeting. A summary of the questions received is included below.

2. The Board were asked about the representation from North East Hampshire & Farnham and Guildford and Waverley on the Mental Health Partnership Board and noted that there had been relatively few user and carer representatives at a recent mental health public engagement event. Dr Andy Whitfield advised that North East Hampshire & Farnham Clinical Commissioning Group was the lead commissioner for mental health and learning disabilities in Surrey and viewed this as hugely important. He advised that a colleague from North East Hampshire & Farnham Clinical Commissioning Group chaired the Mental Health Partnership Board but that he, with the Chair of Guildford and Waverley Clinical Commissioning Group would look into ensuring appropriate representation.

3. In response to a question, the Chairman confirmed that an update on autism would be considered at a future Board meeting.

4. The Board noted the support that could be provided by Community Connections in helping people keep well in their local communities and retain their employment and encouraged the Board to refer into the service.

Actions/Next Steps:
Jo Poynter to arrange for the Board to receive a presentation on the findings of the Autism Self Assessment Framework.

Meeting ended at: 3.25 pm

Chairman

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Meeting dates	**3 April 2014 PART PUBLIC**	**5 June 2014 PUBLIC**
Time & Venue	**1-4pm Council Chamber, Woking Borough Council**	**1-4pm Reigate & Banstead Town Hall**
Planned agenda items	JHWS Priority: Older Adults Health and Wellbeing – sign off Better Care Fund Final Plan – sign off	JHWS Priority Plan: safeguarding the population Clinical Commissioning Group Commissioning Strategies – alignment with the JSNA and JHWS JHWS Priority Plan: emotional wellbeing and mental health - update
30 mins	Public engagement session (including an update on the consultation for the alcohol section of Surrey's Substance Misuse Strategy)	Public engagement session

PLEASE NOTE – the forward work plan for the Health and Wellbeing Board is being fully refreshed in May 2014 and an update version will be presented to the Board at it's meeting on 5 June 2014.

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Protocol: Health and Wellbeing Board, Children and Young People's Partnership and Safeguarding Adults and Children Boards

This paper sets out the proposed working arrangements between the Surrey Health and Wellbeing Board (HWB), the Surrey Safeguarding Adults Board (SSAB), the Surrey Safeguarding Children Board (SSCB) and the Surrey Children and Young People's Partnership (CYP). It provides an overview of the roles and responsibilities of the four Boards, identifying interrelationships and ways that successful coherence between all will be achieved. Once agreed by all four Boards it shall be incorporated into the Surrey Health and Wellbeing Board's Operating Framework.

Health and Wellbeing Board:

- Assesses the needs of the local population and lead the Joint Strategic Needs Assessment and development of a joint health and wellbeing strategy.
- Promotes integration and partnership working between NHS, social care, education, borough and district councils, public health and the police
- Supports strategic joint commissioning and pooled budget arrangements, where appropriate
- Assesses the health, social care and public health commissioning strategies and plans
- Lead on local health improvement and prevention activity.
- Supports residents' voice and the exercise of patient choice.

Surrey Safeguarding Adults Board:

Works together to ensure effective safeguarding arrangements are in place in the commissioning and provision of services to adults at risk by individual agencies and ensures effective interagency working. Ensures reasonable measures are undertaken to make certain that risks of harm are minimised, particularly in light of the personalisation of care and support around the needs of the individual. Ensures that learning from Safeguarding Adult Incidents are shared and implemented across all agencies where appropriate, to improve prevention for adults at risk

The roles and functions which support these objectives are:

- Developing policies and procedures
- Developing, implementing and monitoring work plans
- Communicating and raising awareness
- Monitoring and evaluating the effectiveness of partners individually and collectively
- Undertaking reviews of all serious case reviews and disseminating the learning

Surrey Safeguarding Children Board:

The SSCB is a statutory partnership with two main objectives as set out in Working Together (2013) and the Children Act 2004 regulations.

1. To coordinate the safeguarding arrangements of each body represented on the Board and promote the welfare of children in their area

2. To monitor the effectiveness of the safeguarding arrangements.

The statutory roles and functions which support these objectives are:

- Developing policies and procedures
- Communicating and raising awareness
- Monitoring and evaluating the effectiveness of partners individually and collectively
- Participating in the planning of services
- Undertaking reviews of all child deaths and serious case reviews and disseminating the learning
- Commissioning and evaluating single and multi-agency training

The Surrey Children and Young People's Partnership:

Purpose
The purpose of the Surrey Children and Young People's Partnership is to provide strategic direction and leadership of the systems change needed to deliver better outcomes across the children's system. The Children and Young People's Partnership Plan (CYPP) sets out the strategic goals for the partnership, and incorporates the Health and Wellbeing Board's priority for children.

Proposed working arrangements

1. The HWB will consult the SSAB and SSCB to validate a summary of the Surrey Joint Strategic Needs Assessment and inform the development of the Health and Wellbeing Strategy
2. The Surrey CYP will consult with the SSCB on the Children and Young People's Partnership Plan and its annual review.
3. The SSAB and the SSCB will formally present their annual reports to the HWB on the effectiveness of safeguarding arrangements and the HWB will provide a formal response to both
4. The HWB shall identify a named individual to ensure co-ordination of relevant activities and champion safeguarding in the work of the HWB
5. HWB members shall ensure messages and information about keeping adults and children safe are disseminated within partner organisations, including collaborating on stakeholder events where appropriate.
6. The members of the four Boards shall take responsibility to ensure safeguarding action taken by one body does not duplicate that taken by another.
7. Ensuring safeguarding is "everyone's business", reflected in the public health agenda and related health and social care commissioning strategies.
8. The SSAB and SSCB will share with the HWB and CYP their strategic plans and priorities for improvement to ensure alignment and best use of resources to protect adults and children at risk

Next steps: HWB, SSAB and SSCB to review Draft Protocol, make amendments and formally sign off.

Surrey Health and Wellbeing Board

Date of meeting	*Thursday 3 April 2014*

Item / paper title: 'Improving Older Adults Health and Wellbeing' Priority: Joint Action Plan

Purpose of item / paper	To approve the Joint Health and Wellbeing Strategy Priority Plan for 'Improving Older Adults Health and Wellbeing'.
Surrey Health and Wellbeing priority(ies) supported by this item / paper	This joint action plan sets out how the Improving Older Adults Health and Wellbeing priority will be delivered.
Financial implications - confirmation that any financial implications have been included within the paper	There are no immediate or direct financial implications resulting from this action plan; spend associated to the actions in this plan are within existing budgets. This joint action plan will provide an overarching framework for spend on services for older people.
Consultation / public involvement – activity taken or planned	This action plan is directly informed by public engagement undertaken as part of the Surrey Ageing Well work programme and ongoing engagement through public and patient engagement forums.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	A comprehensive Equalities Impact Assessment will be undertaken and will form the next progress update for the Board later this year.
Report author and contact details	Jean Boddy, Senior Manager - Commissioning Adult Social Care, Surrey County Council 01483 518474 Jo Alner, Director of Quality and Innovation North West Surrey Clinical Commissioning Group 01372 201818
Sponsoring Surrey Health and Wellbeing Board Member	Dave Sargeant, Acting Director of Adult Social Care Surrey County Council Liz Lawn, GP Clinical Lead North West Surrey Clinical Commissioning Group
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** • endorse the proposed approach and joint action plan for the 'Improving older adults' health and wellbeing' priority; • support the ongoing development and implementation of the joint action plan; and • receive a progress update report in December 2014.

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Health and Wellbeing Surrey

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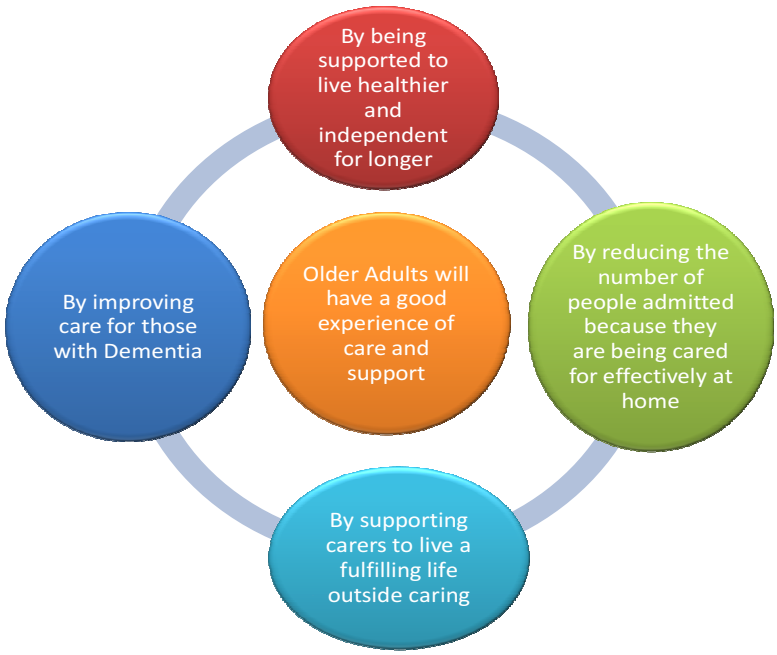
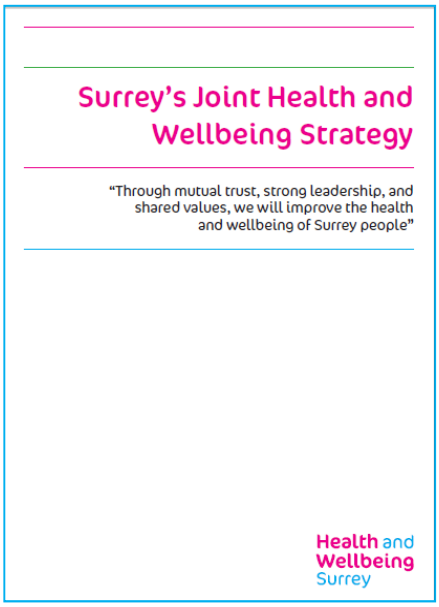
Surrey Health and Wellbeing Strategy: Older Adults Action Plan 2014-2016

Surrey Health and Wellbeing Strategy Older Adult Outcomes



Introduction



Surrey's Joint Health and Wellbeing Strategy, approved in April 2013, sets out five priority areas for Surrey's Health and Wellbeing Board to focus upon - these are:

- Improving children's health and wellbeing
- Developing preventive approach
- Promoting emotional wellbeing and mental health
- Improving older adults' health and wellbeing
- Safeguarding population

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In developing its work programme, and to ensure sufficient focus and time is spent on each priority, the Board decided to tackle each of the five priorities in turn with the aim of translating the high level strategic intentions described in the Strategy into clear sets of actions for the Board and its member organisations to take forward together.

The Board has also agreed a set of cross cutting principles which underpin the Board's work on each of the priority areas:

- Early intervention
- Improved outcomes
- Centred on the person, their families and carers
- Evidenced based
- Opportunities for integration
- Reducing health inequalities

This report provides an update on the work that has been undertaken to develop the Health and Wellbeing Board's action plan for the 'Improving older adults' health and wellbeing' priority – it sets out the rationale for the priority (the evidence base), describes what the work is trying to achieve and also how it will be achieved.

This report should be read in conjunction with Surrey's Better Care Fund report (also being presented to the Health and Wellbeing Board on 3 April 2014) which includes a key focus on integrating services for older adults in Surrey.

The proposed actions and approach described in this report are aligned to the policy and strategic intent already set out in Surrey's six Clinical Commissioning Group Commissioning Strategies and the County Council's Adult Social Care Directorate Strategy.

Background

This joint action plan describes how health and social care commissioners, in partnership with older adults, will support local organisations to improve the lives of older residents in Surrey. Health and social care commissioners[1], both independently and collectively, have an enormous opportunity to radically reshape the way in which care and support is provided to older adults.

This plan has been written at a time when central government is asking health and social care to gather momentum towards 2015/16, when the Better Care Fund[2] will support a fuller integration of health and social care. It will do this by identifying new ways of working and transforming services, to deliver outcomes for the benefit of residents in Surrey. The outcome based approach to commissioning services for older adults' sets out future ways of delivering care in Surrey. This shift means we (the Surrey Health and Wellbeing Board) as commissioners will move away from commissioning purely for a service itself, but a move towards measuring outcomes as defined by the older adult and their carer. As the Better Care Fund encourages us to work closer together, it is therefore an important way of delivering this joint plan.

Why is this action plan needed?

The population aged over 65 and over 85 years old is projected to grow at around the same as the national average. Improvements in health and wellbeing and residents living longer are a cause for celebration. The ageing population also means that Surrey will have a growing proportion of residents with increasing health and social care costs and have conditions that require additional care needs including:

- Dementia and depression
- Visual and hearing impairment
- Long term health conditions as a result of a stroke
- Frailty and being prone to falls and consequent fractures (particularly hip fractures)
- An inability to manage domestic tasks, self-care or move around on their own.
- Social isolation

[1] Health commissioners are known as Clinical Commissioning Groups (CCGs) that replace former Primary Care Trusts and are responsible for delivering NHS services in local areas. There are six CCGs in Surrey. Social care commissioners are Surrey County Council.

[2] The Better Care Fund nationally combines some existing budgets into one health and social care pot. The fund is not additional money; instead it brings together NHS and local government funding that are already committed to services. It will provide an opportunity to improve services and value for money, through a requirement to work closer together than ever before.

Additionally, older adults are more likely to have multiple chronic diseases requiring multiple medications and to be in the later stages of the disease when complications have manifested. Therefore improving end of life care for our population is a priority; ensuring people and their families are able to access the care they need, as well as die with dignity in their preferred setting of care will be a focus of this action plan.

The current consequence of the demographic changes is causing significant financial and service pressures. To respond, health and social care commissioners must redesign services that promote prevention and wellbeing, as well as services that are sustainable and affordable. To meet this challenge, any service redesign needs to be a radical redesign of the delivery and supply of health and social care and support services in our locality.

We also recognise the important role that family, carers, friends and the wider community have in maintaining good health and wellbeing. These can often support older people to maintain an active role in the community, give advice and information and remain independent. Voluntary and faith sector organisations play a key role in supporting older adults in Surrey and we are committed to maximising their contribution.

The evidence - our Joint Strategic Needs Assessment tells us that:

- The number of older people aged 65 and over in Surrey is projected to rise from 181,500 in 2013 to 233,200 in 2020
- It is estimated that the number of people aged 85 and over in Surrey will increase from 32,000 people in 2013 to 46,000 by 2020
- Dementia is a significant issue in Surrey. Around 14,500 people over 65 have a diagnosis of dementia, but this is likely to be an under-estimate
- Although the 65+ population accounted for 17.6% of the county's total population in 2011, people aged 65 or over accounted for almost 41% of all hospital spells in Surrey from 2011 to 2012, and accounted for over 67% of total bed usage
- Around 75,000 people over 65 have a long term health condition, which is projected to rise to 90,000 in 2020
- An estimated 7,770 carers aged 65 and over are providing more than 20 hours of care every week
- People from all ethnic groups are affected by dementia. Across the country the number of people with dementia in minority ethnic groups is around 15,000 but this is set to rise sharply. People from some communities access support services less than people from other communities. This is because of many different reasons, for example language challenges (in many Asian languages there is no word for dementia) or social stigma.

Annex one provides links to a range of evidence sources which have informed the work on this action plan.

Surrey has a rapidly ageing population that requires more joined up out-of-hospital care to enable older adults to stay independent, healthy and well. It is therefore important that we develop an integrated model of health and social care, linked into services such as; mental health, nursing and residential homes and care at home, as well as services provided by borough and district councils, such as Telecare, handyman, care and leisure services.

What are we trying to achieve?

The joint action plan (annex two) summarises what health and social care commissioners have agreed to deliver together. The actions are listed alongside four of the desired outcomes defined in Surrey's Joint Health and Wellbeing Strategy:

- Older adults will stay healthier and independent for longer
- More older adults with dementia will have access to care and support
- Older adults will experience hospital admission only when needed and will be supported to return home as soon as possible
- Older carers will be supported to live a fulfilling life outside caring.

All of the actions will contribute to the achievement of the fifth desired outcome defined in the Strategy – 'Older adults will have a good experience of care and support' and the proposed approach is also aligned to the 'Ageing Well Commitment'[3] (see annex three)

The joint action plan will be delivered from 2014 - 2016 – each action has an identified measure of success and it is proposed that progress against each outcome will be reported on 6 monthly basis to the Surrey Health and Wellbeing Board. In addition each of the action plans will be shared via local Older People forums, Patient and Carer Forums and the Ageing Well group. The individual action plans have already been developed within each CCG locality and are being progressed and driven through Locality Better Care commissioning boards.

The first progress report will be made in December 2014.

What will help us make the plan happen?

- Working in partnership:

Health and social care commissioners will work in partnership to support and influence decisions with local planners and housing partnerships to address inequalities. The plan also recognises the essential role that a well planned community infrastructure has in supporting health and wellbeing and sustaining care and support at home through housing adaptations and Disabled Facilities Grants.

In order to achieve the outcomes of this action plan we will have in place some key enabling systems that will help deliver better outcomes for older

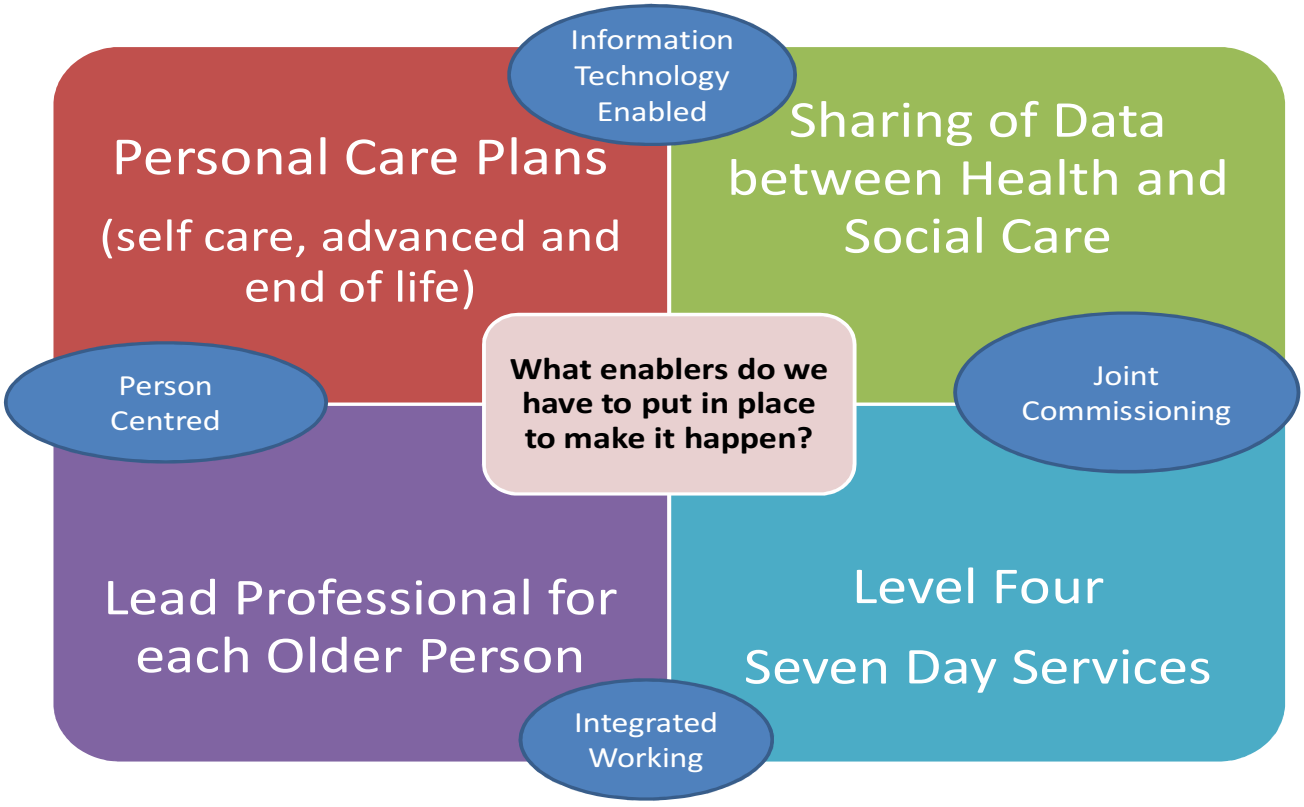
[3] The **Surrey Ageing Well Commitment**3 is a public statement of intentions that offers local organisations a set of shared guiding principles and values to help plan and deliver services in conjunction with local people.

people. These will include joint commissioning, better data-sharing, **seven day working** across health and social care services and an **accountable lead professional** for packages of integrated care for older people.

The **personal care plan** is a plan developed with health or social care support that contains information about health, lifestyle, preventative options, social and community support, and options for treatment or care. It addresses a person's personal situation as a whole, recognising that the persons has a range of needs and outcomes, not just medical that will support total health and well-being.

7

The safe, secure technology to support **sharing of data** in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information, fostering a culture of secure, lawful and appropriate communication to support better care.



As the detailed work on the action plan develops, the lead organisations involved may feel that developing integrated service models will deliver the best outcomes for service users / patients - those organisations will then define the most appropriate model of integration and seek approval from their organisation as appropriate (e.g. through the Clinical Commissioning Group governing bodies, County Council's Cabinet and other partners governance mechanisms).

Annex one: the evidence base

Ageing Well in Surrey
http://www.surreycc.gov.uk/__data/assets/pdf_file/0020/452126/CS2444-Ageing-Well-Commitment_WEB.pdf

Health Checks Implementation and Review
https://www.gov.uk/government/publications/nhs-health-check-implementation-review-and-action-plan

Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care
http://www.nice.org.uk/nicemedia/pdf/ph16guidance.pdf

Falls Prevention Assessment and Prevention http://guidance.nice.org.uk/CG161

Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency
www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1518-082_V01.pdf

Avoiding Hospital Admissions: Lessons learnt from evidence and experience
http://www.kingsfund.org.uk/publications/articles/avoiding-hospital-admissions-lessons-evidence

Dementia Pathway http://pathways.nice.org.uk/pathways/dementia

Dementia Quality Standards www.guidance.nice.org.uk/QS1

Dementia: Supporting people with dementia and their carers in health and social care
www.nice.org.uk/nicemedia/pdf/cg042niceguideline.pdf

Quality standard for Supporting People to Live with Dementia
http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30

End of Life Care NICE guidelines www.guidance.nice.org.uk/QS13

Transforming Urgent care and emergency services
www.nhs.uk/NHSEngland/keogh-review/.../UECR.Ph1Report.FV.pdf

Equality For All: Delivering Safe Care 7 Days Week
www.improvement.nhs.uk/documents/SevenDayWorking.pdf

Improving General Practice. A Call for Action
www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf

Support for Carers of Older People
www.audit-commission.gov.uk/.../OlderPeople_5_Report.pdf

Integrated Care Models that work on frail older people
http://www.kingsfund.org.uk/topics/integrated-care

Example – Warwick http://www.hsj.co.uk/resource-centre/best-practice/local-integration-resources/the-principles-behind-integrated-care-for-older-people/5051571.article

Annex two: Improving older adults' health and wellbeing action plan 2014 - 16

Outcome One	**Older Adults will stay healthier and independent for longer**
Why is this a priority?	We plan to reduce incidence of disease which can shorten life or increase disability in later life and support the delivery of primary and secondary prevention measures for those at risk of diabetes, cancer, cardiac and stroke.

Action	North West CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting officer	By when
Increasing the no. of cardiovascular Health Checks completed.	√	√	√	√	√	√	√	√	Increase in uptake of CVD Health Checks	Joanne Alner	June 2015
Increasing the no. of people living with an undiagnosed LTC, receiving a diagnosis and access to treatment.	√	√	√	√	√	√	√	√	Reduce the gap between the expected prevalence and actual no. of those diagnosed with Diabetes, CHD and COPD	Joanne Alner	June 2015
Targeting prevention initiatives (including diet, exercise, smoking and alcohol) at higher risk communities and individuals.	√	√	√	√	√	√	√	√	Reduce premature mortality for at risk groups	Helen Atkinson	June 2015
Increasing the number of people with a self management care plan	√	√	√	√	√	√	√	√	Increase in the no. people who have a self care management plan	Joanne Alner	June 2015
Increase in the use of assistive technology, such as Telecare and Telehealth.	√	√	√	√	√	√	√	√	Increasing no. of people supported to live independently with technology Increase in the no. of people using technology to support self care management	Joanne Alner/ Jean Boddy	March 2015

Outcome Two	**Older adults with dementia will have access to care and support**										
Why is this a priority?	We are aware that with an ageing population, there are more people in Surrey living with dementia, many of whom are currently undiagnosed and therefore unsupported. We are aiming to diagnose dementia earlier and look after people better so they can live with the condition at home for as long as possible.										
Action	**North West Surrey CCG**	**Guildford & Waverley CCG**	**Surrey Heath CCG**	**Surrey Downs CCG**	**North East Hampshire & Farnham CCG**	**East Surrey CCG**	**Public Health**	**Adult Social Care**	**Measure of success**	**Reporting officer**	**By when**
Increasing the number of people who receive an earlier diagnosis of dementia and access to effective treatment and support in conjunction with Adult Social Care and Public Health	√	√	√	√	√	√	√	√	Reduce the gap between the expected prevalence and actual number of those diagnosed with Dementia	Joanne Alner/ Donal Hegarty	June 2015
Increasing support for people in crisis to prevent admission of those people they care for with dementia	√	√	√	√	√	√	√	√	Decrease in emergency admissions to nursing/care homes or hospital due to breakdown of support	Joanne Alner	June 2015
Increasing specialist support for those caring for and with dementia to support earlier discharge from hospital	√	√	√	√	√	√	√	√	Reduction in length of stay and excess bed days	Joanne Alner/ Donal Hegarty	June 2015
Increasing the number of Dementia Navigators and Local Champions – working with Adult Social Care	√	√	√	√	√	√	√	√	Number of people who have accessed a dementia navigator Number of dementia champions	Joanne Alner/ Donal Hegarty	June 2015
Promoting and developing Dementia Friendly Communities	√	√	√	√	√	√	√	√	Project ongoing	Donal Hegarty	June 2015

Outcome Three	**Older adults will experience hospital admission only when they need to access urgent care services and will be supported to return home as soon as possible.**
Why is this a priority?	Accessing urgent care can be confusing and time consuming for all patients, particularly the elderly and frail, as there are many services available and it is not often clear when and where to go. This is resulting in unnecessary admissions to our acute hospitals for conditions that could be managed within the local community.

Action	North West Surrey CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting Officer	By when
Increasing the use of risk stratification tool to identify those most at need and proactively directing services to them	√	√	√	√	√	√	√	√	Increase in the % of people in medium to high risk category receiving care	Joanne Alner	March 2015
Investment in the health and social care workforce, bringing the right values and skills specialised in and dedicated to assessing, treating and supporting the frail elderly	√	√	√	√	√	√	√	√	Reduction in emergency admissions and A&E attendances Reducing excess bed days and LOS.	Ken Akers/ Jean Boddy/ Joanne Alner	June 2015
Health and Social care working together to develop and redesign services to enable older adults to be cared for at home or helping them to return home from hospital soon as possible	√	√	√	√	√	√	√	√	Reduction in emergency admissions and attendances at A&E. Reduction in excess bed days and LOS. Decreasing the number of people requiring a nursing or care home.	Joanne Alner / Jean Boddy	June 2015

Reframing the threshold and use of community beds, including nursing and rest home.	√	√	√	√	√	√	√	√	Reduction in emergency admissions Reduction in excess bed days and LOS	Joanne Alner/ Jean Boddy	June 2015
Increasing the scope and number of older people receiving personal health budgets and direct payments	√	√	√	√	√	√	√	√	Decreasing the number of people requiring a nursing or care home Increasing the number of carers receiving financial support	Joanne Alner/ Jean Boddy	June 2015
Proactively planning for the end of life, for people to die in their chosen place as much as possible.	√	√	√	√	√	√	√	√	Increase in the no. on an electronic register (Palliative Care Co-ordination System). Increase in the no. of people who have an electronic advanced and end of life care plan. Increasing the no. of people who die in their preferred place. Reduction in the number of unscheduled admissions for patients in their last year of life. Increase in no. of nursing homes with GSFCH accreditation.	Joanne Alner /Jean Boddy	June 2015

Outcome Four	**Older Carers will be supported to live a fulfilling life outside caring**
Why is this a priority?	We want to promote caring and support those who do it. We support the Surrey Joint Strategy for Carers, in particular the focus on the older person as a carer. It is important that carers have their own care plans as well as the individuals they are caring for; to support their own physical and mental health needs.

Action	North West Surrey CCG	Guildford & Waverley CCG	Surrey Heath CCG	Surrey Downs CCG	North East Hampshire & Farnham CCG	East Surrey CCG	Public Health	Adult Social Care	Measure of success	Reporting Officer	By when
Increasing the number of carers identified and involving them in care planning for their relative	√	√	√	√	√	√	√	√	Increase the number of carers know to primary and social care Increase the number of carers with a personal care plan	Joanne Alner/ Jean Boddy & John Bangs	March 2015
Increasing involvement of the third sector and voluntary groups in providing respite, support and recreational activity	√	√	√	√	√	√	√	√	Decreases in the number of caring relationships breaking down Increases in the number of carers accessing employment or recreational activity	Joanne Alner/ Jean Boddy	June 2015
Promoting carers to continue caring through the use of personal health budgets and direct payments	√	√	√	√	√	√	√	√	Increasing the numbers of people accessing personal health budgets and direct payments Reduction in the number of nursing and care home placements	Joanne Alner/ Jean Boddy & John Bangs	June 2015
Proactively supporting carers to be physically and mentally healthy	√	√	√	√	√	√	√	√	Increase the number of carers with a personal care plan	Joanne Alner/ Jean Boddy	June 2015
Providing respite breaks for carers	√	√	√	√	√	√	√	√	Increasing the scope of carers who have accessed planned respite and carer breaks	Joanne Alner/ Jean Boddy	June 2015

Annex three - Ageing Well Commitment

The **Surrey Ageing Well Commitment**[4] is a public statement of intentions that offers local organisations a set of shared guiding principles and values to help plan and deliver services in conjunction with local people. It can be used by the wider public in Surrey to raise awareness and be a 'call to action' when individuals face age inequality in the county. The Commitment ensures that across Surrey collectively and individually organisations are working towards the same aims of changing perceptions of getting older and making Surrey a place where people want to live and age well, as well as tackling geographical isolation and barriers that arise due to belonging to an ethnic minority or faith group. This Older Adults Action plan will endorse and promote the same overall outcomes as the Ageing Well Commitment.

1. I/we will ensure that people feel included as full and equal members of the community and are not socially isolated or excluded. That they have opportunities to be involved socially and economically and are able to play an active role in the community if they wish regardless of age, disability, race, religion or belief, sex, sexual orientation or caring responsibilities;
2. I/ we will enable people to get out and about on transport easily;
3. I/we will ensure people know where to access clear advice and information that will help people remain independent and in control of their lives as they age;
4. I/we will ensure people will have access to supportive technology that enables people to live independently in their own homes;
5. I/ we will encourage people to be active, eat well and be informed about how to stay healthier both physically and mentally;
6. I/ we will ensure people will have access to practical help and support available from competent, trustworthy and affordable agencies for activities such as housework, home maintenance, gardening and shopping;
7. I/ we will ensure that people with additional or particular needs are supported flexibly at critical times, for example those older people living with dementia and older people who need assistance after a period of illness and/ or bereavement; Visit Surrey Information Point for more information about **Dementia Friendly Surrey**, how you can be a champion and apply to the Innovation Fund.
8. I/ we will ensure that support is available to people that allows them to feel safe and secure at home and when out in the community;
9. I/we will ensure that people are as aware of relevant allowances such as the attendance allowance or grants to seek to ensure financial stability with as much control as possible over money;
10. I/ we will ensure that carers will have access to timely and accessible support.

[4] http://www.surreycc.gov.uk/__data/assets/pdf_file/0020/452126/CS2444-Ageing-Well-Commitment_WEB.pdf

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Surrey Health and Wellbeing Board

Date of meeting	3 April 2014

Surrey-Wide Better Care Fund

Purpose of item / paper	1. The purpose of this paper is to invite the Health and Wellbeing Board to review and sign-off the 'final' Surrey-wide Better Care Fund return and to submit to NHS England by 4 April 2014 deadline.
Surrey Health and Wellbeing priority(ies) supported by this item / paper	2. The Better Care Fund (formerly known at the Integration Transformation Fund) is a national fund which was announced in the June 2013 Spending Round. The fund is designed to: • Improve outcomes for people. • Drive closer integration between health and social care. • Increase investment in preventative services in primary care, community health and social care. • Support the strategic shift from acute to community and to protect social care services. 3. The Better Care Fund is part of Surrey County Council's Public Service Transformation Programme. It is aligned with the strategic intent set out in the CCG's Commissioning Plans and the Adult Social Care Directorate Strategy around collaborative working with health and other partners, and the provision of leadership in the joint commissioning of health and social care services. 4. The Surrey-wide Better Care Fund return outlines plans for 2015/16 which will support delivery of Surrey's Joint Health and Wellbeing Strategy and what organisations can do better together. The focus of the return is upon providing better care for older people in community settings. It will therefore have most impact upon delivery of the following priorities: • Developing a preventative approach • Promoting emotional wellbeing and mental health • Improving older adults' health and wellbeing 5. Prevention is a priority in Surrey's Joint Health and

	Wellbeing Strategy which was approved in April 2013 and is at the heart of the Better Care Fund agenda. The Better Care Fund will build on the work already underway in Surrey through the Whole Systems Partnership, the Personalisation and Prevention Partnership Fund etc.
Financial implications - confirmation that any financial implications have been included within the paper	6. The Better Care Fund is made up of a number of existing elements of funding, most of which will come from health budgets (ref Annex 1). The announcement covered two financial years: • For 2014/15, the expected Whole Systems Funding for Surrey = £18.3m. This will be transferred to Surrey County Council with joint investment decisions being made. • For 2015/16, the 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. We are considering putting this into a pooled budget under Section 75[1] joint governance arrangements between Clinical Commissioning Groups and the County Council. The details of this will be consistent with further national guidance and will be finalised by the Better Care Board. 7. It is important to emphasise that this is a confirmation of existing funding continuing and being rebadged, not a new funding stream. It will mean Clinical Commissioning Groups will have to shift existing funding from the acute hospitals in Surrey in order to increase investment in preventative services in primary care, community health and social care. This will require major service change – possibly across Surrey's providers. 8. One of the main conditions of the Better Care Fund is to 'protect' 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". 9. Submission of this return is necessary to obtain full access to the Better Care Fund. As such, it supports the future financial viability of both the County Council and the whole

[1] Section 75 of the NHS Act, providers for Clinical Commissioning Groups and local authorities to pool budgets

	Surrey health and social care system. 10. The Better Care Fund and the associated partnership agenda are welcome. It should be noted that central Government has unhelpfully double counted most of the £65.5m revenue by including it in both the County Council's 'spending power' and Clinical Commissioning Groups funding allocations, so setting up potentially incompatible expectations in both. 11. The return has been jointly agreed between Surrey County Council and the Clinical Commissioning Groups, although further development will be needed during 2014/15 in order to optimise value for money and establish the financial benefits flowing to all partners.
Consultation / public involvement – activity taken or planned	12. 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. Patients, people who use services and the public have been involved through a number of partnership boards and via local engagement events held during 2013. 13. Work on the Surrey Better Care Fund return began in Autumn 2013. Joint workshops, with Adult Social Care and Clinical Commissioning Group representatives, were held in November, January and February. Working together we have produced a coherent and credible plan, which demonstrates our ability to work in partnership despite the challenges and tight timescales. 14. Each of the Local Joint Commissioning Groups has developed a local 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, as well as the need for local ownership and leadership. 15. The Surrey Better Care Fund return (Annex 2 and 3) is a composite Surrey-wide return. It provides an overview of key objectives 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. 16. Key objectives in the Surrey Better Care Fund return are:

	• **Enabling people to stay well**: Maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs. • **Enabling people to stay at home**: Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care. • **Enabling people to return home sooner from hospital**: Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	17. This is a high level return and the detailed local schemes will be planned during the course of 2014/15, for implementation in 2015/16. An Equality Impact Assessment (EIA) will be completed as part of this process to assess the impact upon residents, people who use services, carers and staff with protected characteristics. 18. Equality Impact Assessments have already been undertaken for a number of existing joint schemes which are likely to be rolled forward into 2015/16. These include for example, telecare, reablement, extended hours in the hospitals.
Report author and contact details	Julia Ross, Chief Executive, NHS North West Surrey CCG Tel: 01372 201536 julia.ross@nwsurreyccg.nhs.uk Susie Kemp, Assistant Chief Executive, Surrey County Council Tel: 020 8541 7043 susie.kemp@surreycc.gov.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 'final' Surrey-wide Better Care Fund return and to submit to NHS England by 4 April 2014 deadline

Annexes	Annex 1 Surrey Better Care Fund – Funding Arrangements Annex 2 Surrey Better Care Fund Return (Part 1) Annex 3 Surrey Better Care Fund Return (Part 2)

8

Annex 1

Better Care Fund – Funding Arrangements

The Better Care Fund is made up of a number of existing elements of funding, most of which will come from health budgets, as illustrated in figure 1. For 2015/16, the Better Care Funding total position for Surrey is expected to be a revenue allocation of £65.5m + capital of £6.0m = £71.5m.

8

Figure 1 – Existing elements of funding making up the 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**

Working together, and taking on board the condition to 'protect' social care services, Adult Social Care and the six Clinical Commissioning Groups have agreed the following broad uses of the £65.5m revenue allocation in the Better Care Fund in 2015/16:

Figure 2 - Possible uses of Better Care Fund in 2015/16

	£m	Notes
Care Bill costs	2.5	Government direction
Carers support	2.2	Agreed priority, existing stream
Health reablement/intermediate care	5.0	Existing stream
Ongoing partnership funding eg virtual wards, risk stratification tool, telecare, telehealth, dementia support, reablement etc	14.3	Assumes 2013/14 level of investment carries on
Joint posts to support integration and transformation	0.5	To improve project management capacity
As per local plans and 'protecting' social care services*	41.0	*We expect the benefit to social care in 2015/16 to be £25m
	65.5	

Health and Wellbeing Surrey

Annex 1

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	65.5	

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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.

8

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 and Farnham CCG straddles the counties of Surrey and Hampshire. The CCG has worked in collaboration with both Surrey and Hampshire County Councils and is included in both Local Authority Better Care Fund returns. The CCG's financial allocation has been appropriately split across the two Better Care Fund areas based on population. The CCG has aligned both templates 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 • The population of Windsor, Ascot and Maidenhead CCG crosses Surrey in a very small area. The CCG is consequently making a small contribution to the Surrey Better Care Fund but does not form part of the Surrey planning area • The population of Guildford and Waverley crosses West Sussex in a very small area. Guildford and Waverley CCG is working with the Council and CCG's by contributing to their plans
Date agreed at Health and Well-	**2014**

Being Board:	
Date submitted:	**2014**
Minimum required value of Better Care Fund pooled revenue budget: 2014/15	**£3.5m**
2015/16	**£65.5m**
Total agreed value of pooled revenue budget: 2014/15	**£18.3m**
2015/16	**£65.5m**

b) Authorisation and signoff

8

Signed on behalf of the Clinical Commissioning Group	NHS East Surrey CCG
By	Mark Bounds
Position	Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS Guildford and Waverley CCG
By	Dominic Wright
Position	Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS North East Hampshire and Farnham CCG
By	Maggie MacIsaac
Position	Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS North West Surrey CCG
By	Julia Ross
Position	Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS Surrey Downs CCG
By	Miles Freeman
Position	Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS Surrey Heath CCG
By	Dr Andy Brooks
Position	Clinical Chief Officer
Date	2014

Signed on behalf of the Clinical Commissioning Group	NHS Windsor, Ascot and Maidenhead CCG
By	
Position	Chief Officer
Date	2014

Signed on behalf of the Council	Surrey County Council
By	Dave Sargeant
Position	Interim Strategic Director Adult Social Care
Date	2014

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	2014

8

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.

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.

8

Specifically:

East Surrey CCG	East Surrey CCG ensures that providers are members of the Local Transformation Board and form an integral part of the planning and implementation teams as well as members of relevant and associated workstreams. Furthermore, as part of the planning round, consultation, sharing ideas and negotiations with providers has also taken place. East Surrey CCG have consulted through a series of public meetings on the priorities for their plans and have worked closely with their local partners through the Surrey Health and Wellbeing Board, as well as the local Health and Wellbeing Boards in Tandridge and Reigate.
Guildford and Waverley CCG	Guildford and Waverley CCG chair the Better Care Fund Delivery and Implementation Group (their local joint commissioning group) that feeds into the Local Transformation Board. This group includes both health and social care partners who are working together to co-design the model of care that delivers the ambitions of the Better Care Fund. The implications of the Better Care Fund are well understood by this group and signed up to its delivery. This group has been meeting every three weeks since November 2013 and the Terms of Reference are listed in the related documents section.
North East Hampshire and Farnham CCG	North East Hampshire and Farnham CCG together with Surrey Heath CCG and Bracknell and Ascot CCG have met with Frimley Park Hospital to discuss the potential impact of the Better Care Fund on the Frimley System. A major event was held in January where all 3 CCGs and Frimley Park Hospital discussed the impact of the Better Care Fund over the next 5 years. Ongoing engagement with community providers is currently being undertaken. Detailed discussion has also being undertaken with Royal Surrey County Hospital in conjunction with Guildford and Waverly CCG.
North West Surrey CCG	Service providers have been extensively involved in developing the CCG's strategic and operational plans at both leadership and clinical level. The CCG has established a whole system governance structure reporting to the North West Surrey Transformation Board, the membership of which includes the chief executive and senior clinical leader from each of the provider organisations, Surrey County Council

	and North West Surrey CCG. To realise the opportunities presented by the Better Care Fund, NW Surrey has established a Local Joint Commissioning Group. The North West Surrey CCG Better Care Fund return has been developed through the following process: • Joint Health and Wellbeing Workshops in December 2013, January and February 2014 (health and social care joint planning) • Health and social care North West Surrey specific meetings held during December 2013, January and February 2014 • Presentation and discussion at North West Surrey Clinical Executive in December 2013, January, February and March 2014 (primary and social care) • Presentation and discussion at North West Surrey Transformation Board in February 2014 (all system leaders) • Presentation and discussion with Ashford and St Peters Hospital Foundation Trust during a contract negotiation meeting in February 2014 (acute specific)
Surrey Downs CCG	Surrey Downs CCG has engaged with providers through the: • Monthly Epsom Transformation Boards with Executive representation from primary care, secondary care, social care, mental health, borough councils and the voluntary sector • Monthly Surrey and Sussex Healthcare NHS Trust (SASH) Transformation Boards with Executive representation from primary care, secondary care, social care, mental health, borough councils and voluntary sector • Bi Monthly Kingston Hospital Whole System Partnership Board with representation from CCGs, secondary care, social care, mental health, borough councils and the voluntary sector • Monthly Urgent Care Boards (across SASH, Kingston and Epsom)
Surrey Heath CCG	Surrey Heath CCG has engaged with Frimley Park Hospital to develop Better Care fund plans as follows: • Better Care Fund plans (process, financial and activity implications) have been shared with senior managers within the Trust • Three commissioners around the Frimley Park Hospital system (three HWBB) have recognised the need to co-ordinate the Better Care Fund plans at the interface with the acute and have agreed a process for doing this through the Frimley Park Hospital Transformation Board • At a Surrey Heath level we have agreed with Frimley Park Hospital a process for their engagement in shaping the detail of the plans and our model for integrated care and a process for developing a detailed transition plan. • Surrey Heath CCG has begun the engagement/co-design process with all providers - Virgin, SABP, voluntary sector, and primary care.
Surrey County Council	Surrey County Council began to engage with members of Surrey Care Association in February 2014 on the emerging Better Care Fund plans. Surrey Care Association is the organisation which represents

8

social care and nursing home providers (private, voluntary or charitable) based in Surrey from all sectors ie care homes, domiciliary care and supported living. The Council also began the process of engaging with key stakeholders from across community health provider, the voluntary sector and user and carers groups through the Adult Social Care Implementation Board in January 2014. Further discussions and engagement activity is planned during 2014/15 as part of detailed local planning.

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 which started in January 2014.

8

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 Disability Alliance and Network (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:

East Surrey CCG	East Surrey CCG consultations have continued with patients and the public from the initial 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. They also have a well-established Patient Reference Group that has been in place for over 2 years and consists of patients from each of their member practices. They are currently engaging local communities through a series of public meetings. These meetings

	have focused on the national 'Call to Action' programme and how this relates to the local NHS.
Guildford and Waverley CCG	Guildford and Waverley CCG's engagement with local people began in October 2013 when the CCG launched its commissioning intentions and used their Patient and Public Engagement (PPE) forum to communicate the high level changes that they expected the Better Care Fund to bring about. The CCG has a further PPE forum in April 2014 where they will be exploring the detailed service delivery model. The stakeholder engagement project timeline is listed in the related documents section.
North East Hampshire and Farnham CCG	North East Hampshire and Farnham CCG held stakeholder events relating to their local integration plans in November, December 2013 and January 14. Feedback from all stakeholder events is reflected in the CCGs Better Care Fund Plans. North East Hampshire and Farnham is in the process of developing a comprehensive local communication and engagement strategy. There is more detail on their broader engagement strategy in the Hampshire Better Care Fund plan.
North West Surrey CCG	North West Surrey CCG has been working with stakeholders and the local population to define and agree the strategic commissioning plan for the next five years. The CCG has an extensive infrastructure to enable patient and public engagement at practice, locality and CCG level. In addition the CCG is developing processes that enable randomised and representative patient feedback from the 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 they develop and finalise plans for changes to pathways and service delivery. The feedback received from GP patient participation groups across our three localities towards the end of 2013 was themed as follows: • Alternative options to attending A&E • Extended opening hours of GP surgeries, enabling more appointments, with improved out of hours service • Shared care information • Education and information sharing for patients • Improve communication between all sectors
Surrey Downs CCG	Surrey Downs CCG is committed to working in partnership with local people and partners to deliver real improvements in health outcomes for the local population. The CCG's Communications and Engagement Strategy sets out the commitment and approach adopted to engage local people. Surrey Downs has engaged with local people and partners on the design of the service specification for the new out of hours GP service, their Out of Hospital Strategy, plans to improve dementia services and the procurement of an X-Ray service in Dorking. The vision that underpins their wider commissioning plans is set out in their Out of Hospital Strategy which has been discussed and presented at the November 2013 Governing Body meeting in public and discussed through their Patient Advisory Group.
Surrey Heath CCG	Surrey Heath CCG holds quarterly engagement events with its local community and patients, service users, voluntary

8

	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. The Better Care Fund plan will be integrated into the work at borough level through the local Health and Wellbeing Board with key project/intervention being part of our Surrey Heath Partnership Plan. The Surrey Heath Partnership includes representatives from the voluntary and faith sectors, housing, fire services, local business and the police as well as other statutory agencies. An example of how housing services are already integrated into plans is demonstrated in the Supplementary Submission Information in the related documents section. Better Care Fund integration with community safety objectives (police) will also be achieved through this plan. Joint working with the police already takes place at a local level including the sharing of data to reduce A&E attendances.
Surrey County Council	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, seeking feedback and further opportunities for co-design. Feedback will inform and shape our detailed plans for 2014/15 and beyond to ensure local services are integrated, responsive, affordable and meeting the needs of local people.

8

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.

In each of the six systems the governance arrangements require that strategic commissioning decisions are approved by the CCG governing bodies and that the clinical community has played an active role in development. In the County Council there are requirements to involve staff and Members in decision-making processes. The list below therefore provides examples of related documentation as evidence, but does not included public board and committee papers that are available on each organisation's website and demonstrate how established governance requirements are followed.

Document or information title	**Synopsis and links**
Surrey wide	
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 Strategic Needs Assessment	How the CCGs and Adult Social Care identify and describe the health, care and well-being

Document or information title	Synopsis and links
	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 Commissioning Intentions	Commissioning priorities/intentions of each of the Clinical Commissioning Groups and Surrey County Council
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
Adult Social Care Commissioning Strategy for older people in Surrey 2011-2020	The broad strategic direction for Surrey County Council's Adult Social Care Commissioning Service for older people over the next 9 years
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 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
Dementia and Older People's Mental Health Joint Commissioning Strategy	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey for Dementia and Other People's Mental Health over the next 5 years
Joint Commissioning Strategy for Adults with Long Term Neurological Conditions	Joint strategic direction for the Adult Social Care Commissioning Service, NHS Surrey and Neurological Commissioning Support for Adults with Long Term Neurological Condition over the next 4 years
Joint Commissioning Strategy for People with Sensory Impairment 2011-2015	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey for People with Sensory Impairment over the next 4 years
Joint Accommodation Strategy for people with care and support needs	Joint strategic direction for the Adult Social Care Commissioning Service and the 11 Districts and Boroughs on housing for people with care and support needs over the next 4 years
Joint Commissioning Strategy for Advocacy 2012-2016	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey on Advocacy over the next 4 years
Adult Social Care Information and Advice Strategy	Strategic direction for the Adult Social Care Directorate and documents current provision of information and advice services from 2010-2013
East Surrey CCG	
East Surrey CCG Strategic Plan 2014/15-	Describes the vision of the CCG and blue print

8

Document or information title	Synopsis and links
2018/19	for care in the future as well as the phases in the trajectory for getting there and programmes and projects integral to achieving the vision. Also highlights the evidence base on which the blue print (and related projects and programmes) has been designed.
East Surrey CCG Operating Plan 2014/15 – 2015/16	Describes, in more detail what the CCG will be undertaking over the next two financial years on its path to achieving its vision
East Surrey CCG Commissioning Intentions 2014/15	Describes for the forthcoming financial year what and how the CCG will be commissioning.
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)
East Surrey CCG: Local Transformation Board Terms of Reference	Describes the purpose, goals and structure of the Board and how this supports the transformation of the health economy including patient and provider participation.
East Surrey CCG: Practices Commissioning Committee Terms of Reference	Describes the purpose, goals and structure of the Practices Commissioning Committee and how this supports the transformation of the health economy including patient and provider participation
East Surrey CCG: Patient Reference Group Terms of Reference	Describes the purpose, goals and structure of the Patient Reference Group and how this supports engagement with patient and health service users
East Surrey CCG Patient Engagement and Communication Strategy	Highlights the approach that the CCG takes in engaging and communicating with patients and health service users.
East Surrey CCG Call to Action Report	A report post an engagement event that captures and highlights patient views on health services
Frimley System Dementia Strategy and Frimley DLIG Dementia Pathway	System wide dementia strategy and pathway to improve outcomes for the population
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Guildford and Waverley CCG	
Guildford and Waverley CCG Carers Support	Commissioned carers services and how this contributes to the delivery of health outcomes
Guildford and Waverley CCG Investing in Primary Care	Describes how the £5 per head will contribute to the delivery of BCF outcomes
Guildford and Waverley CCG Integrated ICT care model	Sets out the resources mobilised within community services to support integration of

Document or information title	Synopsis and links
	the discharge component of the frail elderly pathway
Guildford and Waverley CCG planning objectives 2014/15	We have objectives for our population which includes measures of health gain, quality premiums, and productivity gains
Guildford and Waverley CCG Primary Care Plus+ Strategy, overview, Co-design report and project timeline for the implementation, risk log and integrated workforce planning template	A model for the operational integration of services with Primary Care
Guildford and Waverley CCG stakeholder engagement project timeline	Timeline sets out our stakeholder engagement activities for the Better Care Fund
Guildford and Waverley CCG Unplanned Care Acute Care Changes Better Care Fund Changes	Describes the detailed impact on the acute sector
Guildford and Waverley CCG Risk Log	Key risks associated with the Better Care Fund
Guildford and Waverley CCG Urgent Care Strategy	Describes the future system of access urgent care including A&E
Guildford ad Waverley CCG Better Care Fund Delivery and Implementation Group Terms of Reference	Terms of Reference for the local joint commissioning delivery forum for the Better Care Fund
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
North East Hampshire and Farnham CCG	
North East Hampshire and Farnham CCG 5 Year Vision	Vision and commissioning strategy for 2014 to 2019
North East Hampshire and Farnham CCG System Transformation Programme	Transformation Programme across the Frimley System in collaboration with NHS Surrey Heath CCG and NHS Bracknell and Ascot CCG
North East Hampshire and Farnham CCG Vision for Primary Care	System wide vision for the involvement and development of Primary Care services
North East Hampshire and Farnham Integration Programme Plan	
North East Hampshire and Farnham CCG Report on Stakeholder Event	Feedback from local stakeholder event demonstrating influence on joint Better Care Fund plans
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
North West Surrey CCG	
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
North West 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

8

Document or information title	Synopsis and links
North West Surrey CCG Expression of Interest in Prime Ministers Challenge Fund	A submission to the DH to become a pilot site to move forward with enhancing delivery of primary care over our three localities
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Surrey Downs CCG	
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
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Surrey Heath CCG	
Surrey Heath CCG Engagement Timeline	
Surrey Heath CCG Supplementary submission information	
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme

8

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?

Surrey County Council is an upper tier local authority comprised of eleven lower tier local authorities. Six CCGs sit on the Surrey Health and Wellbeing Board although North East Hampshire and Farnham CCG only has five GP practices within Surrey. The 2011 census records a Surrey resident population of 1,132,390. Of these, 194,470 or 17.2% are 65 and older, and just over 30,000 or 2.7% are 85 and over. 61% or 691,300 are of working age (18-64) while 19.3% (218,500) are under 16. 152,000 or 13.4% of the population live in rural areas. 10% of the over 60 population live in low income households[1].

2010 based population projections predict a 3.8% increase in the total population from 2015 to 2020. By 2020, the 65 and over population is predicted to increase to 19.4% of the total population and the over 85 population is projected to increase to 3.4% of the total. The proportion of under 16s is expected to rise to 20% of the total. The proportion of those of working age is predicted to fall slightly to 58.4% of the total.[2] Life expectancy is above the England average. There are an estimated 55,000 people in Surrey with a moderate physical disability and a further 16,000 with a serious physical disability. There are an estimated 21,000 people with learning disabilities, more than 4,100 of whom are over 65. It is estimated that of over 106,000 carers in Surrey, nearly 10% of the population, 24,000 are over 65 and 7,800 provide care for more than 20 hours a week. There are approximately 12,000 young carers in Surrey.[3]

[1] JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938

[2] Projections: http://www.surreyi.gov.uk/RealmDataBrowser.aspx?GroupID=0&filterDataSetID=933

[3] JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938

The total registered list size of those practices in the 5 Surrey CCGs and the 5 practices within the Surrey County boundary in North East Hampshire and Farnham CCG is 1,172,300[4]. Surrey has an aging population which means the prevalence of long term conditions will increase. 7,013 are on GP dementia disease registers in Surrey while more than 16,000 are estimated to have dementia, indicating a substantial diagnosis gap[5]. It is suggested that 40% of admissions into long term care are due to older people experiencing falls[6]. There were over 1,300 hip fractures in those aged 65 and over in 2011-12[7]. Around 39,000 people over 65 are unable to manage at least one physical activity on their own[8]. The major killers in Surrey are cardiovascular disease and cancer, though mental illnesses accounted for more than 10% of the PCT spend in 2012-13[9].

Our vision and values

Surrey's Joint Health and Wellbeing Strategy vision for health and social care services for 2018/19 is:

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

8

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:

4 QOF 2012-13: http://www.hscic.gov.uk/article/2021/Website-Search?productid=12972&q=qof&sort=Relevance&size=10&page=1&area=both#top

5 POPPI: www.poppi.org.uk

6 JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938

7 Source: Public Health England National General Practice Profiles: http://www.apho.org.uk/PracProf/Profile.aspx

8 JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938

9 Programme budgeting data: http://www.networks.nhs.uk/nhs-networks/health-investment-network/documents/2012-13%20Benchmarking%20tool_Published%2021%20Feb%202014.zip

- 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. We support the National Voices definition of integrated care as meaning person-centred, coordinated care reflected in the statement " I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". We are working together to ensure the services that we commission meet our strategic aims and programme objectives. It will mean people in Surrey will benefit through:

8

Our Objectives	**People will benefit through**
Enabling people to stay well - Maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs	• Being able to stay healthier and independent for longer with choice and control over their lives and indeed where they die • Knowing about and being able to access information, care and support in their local community to keep them at home • Being part of their local community
Enabling people to stay at home - Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care	• Experiencing health and social care services which are joined up • Receiving a consistent level of care and support 7-days a week • Remaining safe
Enabling people to return home sooner from hospital - Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home	• Knowing they will only be admitted to a hospital if there is no other way of getting the care and support they need • Being supported to return home from hospital as soon as possible and being able to access care and support to help get them back on their feet • Being happy with the quality of their care and support, no matter who delivers it

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 - this is a key focus for health and social care partners.

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.

8

Our aim

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.

Our objectives

The objectives of our enhanced and integrated model of community based health and social care will be:

- **Enabling people to stay well -** Maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs
- **Enabling people to stay at home -** Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care
- **Enabling people to return home sooner from hospital** - Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home

We will measure these 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
- Improve care in sustaining independence and improving quality of life for people with dementia

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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The Joint Strategic Needs Assessment (JSNA) is a key part of, and has informed, each locality's joint plan, encompassing data and information about the Surrey population, which helps us to assess their needs both now and in the future. This has helped us to identify the main health inequalities within the following areas:

- Demographic factors such as changes in the population's age structure, ethnicity
- Socio-environmental issues impacting upon health and social wellbeing such as housing, crime, deprivation, education, the local economy and employment
- Lifestyle factors such as alcohol consumption, smoking, eating healthily
- Prevalence of specific diseases and conditions such as dementia, stroke, coronary heart disease, long term conditions

Surrey's Joint Health and Wellbeing Strategy was developed with Surrey residents, partner organisations and key stakeholders to identify our five key priorities which are aligned with the local joint health and social care work programmes:

- Improving children's health and wellbeing
- Developing a preventative approach
- Promoting emotional wellbeing and mental health
- Improving older adults' health and wellbeing
- Safeguarding the population

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, aim and objectives set out in the Surrey Better Care Fund template, these align with the Health and Wellbeing Strategy and the JSNA priorities. 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 objectives 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 outcomes and experience for the population.

1. **Enabling people to stay well** - Maximising independence and wellbeing through prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs

   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

The key success factors will be:

Metric 4: Avoidable emergency admissions
Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 5: Patient / service user experience
Outcome: Improved satisfaction with health and social care services

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Metric 6: Estimated diagnosis rate for people with dementia
Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place

2. **Enabling people to stay at home** - Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care

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

- Establishing local integrated community teams organised 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 the 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
- 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
- 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

The key success factors will be:

Metric 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000
Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 3: Delayed transfers of care from hospital
Outcome: More individuals have their health and social care needs met in the most appropriate setting

Metric 5: Patient / service user experience
Outcome: Improved satisfaction with health and social care services

Metric 6: Estimated diagnosis rate for people with dementia
Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place

3. **Enabling people to return home sooner from hospital** - Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home

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

The key success factors will be:

Metric 2: Proportion of older people who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services
Outcome: Ongoing sustained level of independence and recovery for people with long term health and care needs

Metric 5: Patient / service user experience
Outcome: Improved satisfaction with health and social care services

The Care Bill

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

Carers Support

With specific reference to our duty to carers as part of the Better Care Fund, Surrey will continue its commitment to:

- Carers Breaks services designed to promote carers independence and wellbeing; delivered through home based breaks services including in end of life situations and also through breaks payments approved by GPs (anticipated cost £2.2 million pa)
- Increase capacity in independent preventative carers services to reduce carers needs for support from statutory services (including for young carers) and carers posts in social care teams; each to respond to new duties to help carers arising from the Care Bill (anticipated cost £720k pa)

Disabled Facilities Grant

Surrey has committed to ring fence the Disabled Facilities Grant element of the Better Care Fund in 2015/16. The Local Joint Commissioning Groups will work with the 11 Borough and District Councils, as the local housing authorities, to ensure the provision of adaptation is incorporated into local investment plans and strategic considerations. The focus will be upon improving the efficiency and delivery of Disabled Facilities Grants in Surrey and ensuring investment reflects local need and enables people to be as independent as possible.

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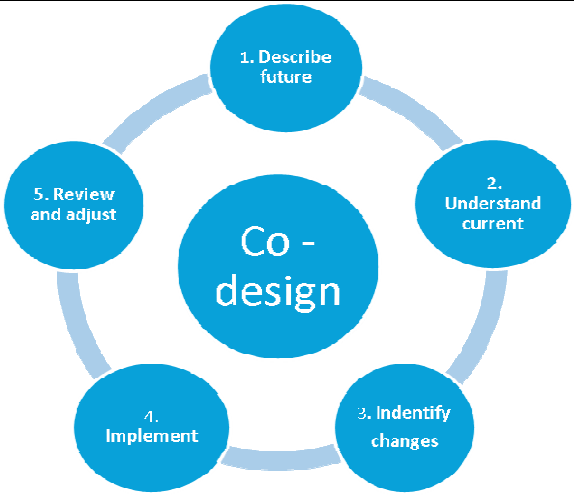
Key enablers

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
- 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
- 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. Specifically:
    - This Better Care Fund requires new ways of thinking about workforce competencies as part of an integrated model of care. Our care workforce will need to develop core competencies, which mean that any qualified professional can conduct holistic assessments that cover a person's health, social care, practical support and mental health needs.
    - As partners we are committed to working with Workforce Deaneries and Training Programmes in Health and Social Care to provide continuing professional development for existing staff and provide placements for trainees pre-registration training.
    - Our model promotes support that ensures people are treated by professionals with appropriate competencies to provide safe, personalised and effective care. We are working on where best to locate Senior Clinicians and Practitioners across our pathways to ensure people see a professional with an appropriate level of experience and decision making autonomy at the right point in their journey.

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 the co-design model in the diagram below.



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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

The anticipated time frames for delivery is proposed as:

Q4 13/14
- Begin to collate information on best practice and current services from existing sources. Increased shared understanding
- Refine local Better Care Fund 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 and 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 and key stakeholders

Q1 15/16
- Fully implement pooled budgets and associated 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 and key stakeholders

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c) 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.

Our focus is to reduce pressure in the urgent care pathway and to create an enhanced and integrated model of community based health and social care that 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 work programme 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.

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Our overall assessment of the implications of the Better Care Fund in Surrey is summarised as follows:

Potential Impacts	Financial	Activity	Scope of Service	Workforce
Acute Hospitals	↓	↓	↔	↓
Community Services	↑	↑	↑	↑
Primary Care	↑	↑	↑	↑
Social Care	↔	↑	↔	↑
Mental Health	↑	↑	↑	↑
Voluntary & charitable sector	↑	↑	↑	↑

Specifically:

East Surrey CCG modelling suggests the impact of plans in activity terms will be significant and we will see the following trends occurring:

- Demographic growth will increase activity by approximately 1.1% per annum
- Elective admissions and day cases will follow current trends and will reflect seasonal change as has been experienced previously
- Non-elective admissions will reduce by approximately 5% in years one and two of our plans due to more robust care pathways being implemented, better management of patients with long term conditions and improved coding and counting at our local acute Trust
- First Outpatient attendances will reduce in the first two years of our plans due to improved referral management within primary care, improved access to referral data by practice and proactive management of specialist referrals by enhancing the referral process within primary care.
- A&E activity will continue to decline in line with the current trend; the continued decline will be influenced by increased access to GPs within primary care, better signposting, more accessible primary care services eg telephone triage by local GP and intelligent use of

information available to healthcare professionals, for example risk stratification data.

- All referrals will see a reduction in the later period of our plans due to enhanced skills within primary community care, more alternatives and a reduction in onward referrals as a result of seamless pathways addressing all aspects of care in the correct way on the first occasion.

Guildford and Waverley CCG has worked through the implications for the local acute hospital, Royal Surrey County, at HRG level. This has been through the integrated performance group and service transformation group with the acute hospital. They have been able to crystallise the impact and agree the resulting contract value for 2014/15. A summary of the changes are included in the related documents section but to highlight from the QUIPP they are targeting a 10% reduction in admissions for all non-elective inpatient admissions in 2014-15

North East Hampshire and Farnham CCG has developed trajectories for planned care and non-elective activities and these are being agreed with providers. These plans reflect the local circumstances. Analysis to date indicates that as integrated community services change and develop, we expect the number of general and acute beds will reduce. However, we expect the number of beds will reach a plateau with future growth reflecting the ageing population and long term conditions prevalence. We are planning for a reduction in non-elective admissions over the three to five years. This will have an impact on the acute service capacity. At this stage we are working with acute and community providers to assess the impact of changes and agree how we will commission 7-day services as the norm.

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North West Surrey CCG is working with stakeholders to complete the modelling required to clarify implications of their strategic plans on providers, particularly the acute trust. They are clear, however, that our focus to reduce pressure in the urgent care pathway and develop equivalence with hospital services in the out of hospital environment will ensure that activity risk is better balanced across the system, thereby reducing demand on the acute sector. Whilst the Better Care Fund is principally a commissioner partnership, finalisation and delivery of our strategic plans is predicated on a whole system partnership, led through the North West Surrey Transformation Board. In financial, workforce and resource terms, it is this partnership that will model and work through implications on all parts of the system, ensuring that risk is shared and effectively managed. NOTE – numbers requested

Surrey Downs CCG has modelled its Out of Hospital Strategy with Epsom Hospital which is predicated on flat, minor negative growth over the next 5 years. The Better Care Fund provides additional challenge, with 4% of CCG operating budgets being allocated to joint provision. We are modelling the impact of the Better Care Fund on the revenue assumptions for Epsom Hospital. It is envisaged through collaborative working, focusing on developing the community strategy, that the impact on the acute trust will be mitigated. Surrey Downs expects to reduce 1 in 8 non elective admissions of those over the age of 75. The impact of this change will mainly affect Epsom Hospital and they are working in partnership with the Trust to ensure that interventions are sustainable and will improve patient experience. Though 73% of their unscheduled activity reduction will be at Epsom, as this is a whole system approach, Surrey Downs CCG expects that there will a reduction in unscheduled admissions at Surrey and Sussex Healthcare Trust and Kingston of 11% and 15% respectively.

Surrey Heath CCG The majority savings realised by this plan will be delivered by a reduction in bed based care by health and social care commissioners. This will include a reduction in nursing home and residential care home placements and the length of time of people in residential/nursing care ie we will increase the care provided in the community and the length of time people are able to be managed in their own homes. It will also include a reduction in acute hospital beds, predominately for physical health but some potential exists for improving services in the community for people with mental health issues. Their main acute provider Frimley are aware that the changes which will be required to release the Better Care funding in 14/15 essentially require a 15% reduction in emergency activity 5% in 14/15 and 10% in 15/16 (they have reduced by 4% this year). Frimley and the CCG are working together on design of the

future integrated community service and its interface with Frimley Park Hospital.

Mental health services will be protected so that vulnerable members of thecommunity are not marginalised and prevented access to services. Commissioners will ensure that mental health provision is further integrated within our community model of care, to improve mental health awareness and competencies across the NHS and social care workforce. Specialist provision will be commissioned to support community teams such as mental health practitioners working with community matrons and psychiatric liaison services being an integral part of A&E and medical ward services. This approach to integrating mental health care within the model of out-of-hospital care will ensure that services are protected and continually improved.

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.

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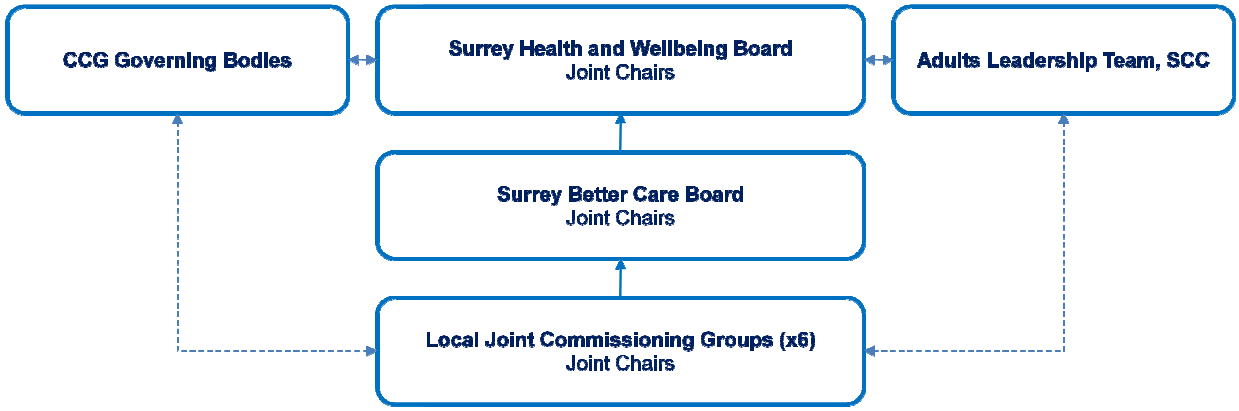
d) **Governance:** Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Our model of governance is shown below and builds on our joint strategic work at the Surrey Health and Wellbeing Board which is co-chaired by a Councillor and a CCG Clinical Chair. We are proposing that from 2014-15 onwards we will build local joint capacity. The governance arrangements in place for oversight and governance of progress and outcomes are proposed as follows:

- There will be 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. This will include budget responsibility with accountability for under/overspend.
- 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 Board will provide strategic leadership across the Surrey health and social care system. The Board will challenge and support the Local Joint Commissioning Groups to deliver improved outcomes for local people.
- Surrey's Health and Wellbeing Board will continue to set and monitor 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.

This form of governance is designed to reflect the Surrey health and social care economy and thus enable each area to address the range of different communities in Surrey as well as the need for local ownership and leadership. We intend to use 2014-15 to trial this model as we will have a mix of schemes rolling forward from the Whole Systems Partnership Fund, many of which will be managed in one of the six localities. The main principle is local joint decision making for patient/client benefit. However we recognise that a risk sharing agreement will be required across all Better Care Fund partners.



3) NATIONAL CONDITIONS

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a) Protecting social care services

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

In Surrey, protecting social care services means sustaining the care and support services needed by local people within the context of increasing demand and further financial constraints. Early interventions will help people to prevent and then to manage their health and social care needs, enabling them to remain in their own homes for longer. We will be evolving new ways of working that join up health and social care so that individuals keep their independence and continue to have a good quality of life. We are committed to sustaining universal and preventative services and to meeting our continuing duty of care to meet eligible assessed need.

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

Social care services will be protected by building upon and sustaining the preventative services developed as part of the Whole System Partnership Fund, intended to reduce demand. 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

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:

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Adult Social Care	• 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 • Delivering reablement services 7.00am – 10.00pm over 7-days a week, supported by a night response service from 10.00pm • Developing a Market Position Statement to signal requirements to the wider market. This will 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
Guildford and Waverley CCG	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. This key scheme will reduce approximately £8m of acute activity for the over 75's through integrating primary and community services, including social care and older adults mental health services. At a practice level this means increasing one additional facilitated discharge per practice per week, and avoiding three preventable ambulatory sensitive condition admissions every two weeks. Increased dementia liaison support to care homes will help to ensure the needs of people with dementia are considered. Rapid discharge and reablement are a critical element of this and will attract significant resources next year to support its success.
North West Surrey CCG	North West Surrey CCG have a 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 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

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.

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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

The first upload of the NHS Number to the Adult Social Care SWIFT/Adults Information System (AIS) took place on 14 March 2014. This is a weekly service to ensure the NHS Numbers in SWIFT/AIS are refreshed and in place to be used as the primary identifier for correspondence.

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.

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.

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Across Surrey a series of risk stratification tools and multi-disciplinary team reviews (including adult social care professionals) are used to identify those adults at high risk of hospital admission. Combined predictive models suggest that 0.5% of the population are much more likely to have an emergency admission, but this is variable across Surrey and can be as high as 5% in some areas. At risk individuals are reviewed and we are working towards all at risk individuals having a joint care plan and accountable professional (GP lead). In the table below there are specific details about risk stratification in each CCG locality.

In addition dementia is a significant issue in Surrey. Around 14,500 people over 65 have a diagnosis of dementia, but this is likely to be an under-estimate. The Surrey Dementia Strategy includes investment to create more robust community services by reducing the unnecessary reliance on inappropriate placements in residential care into community based and preventative services. This is seen as such a key priority for Surrey that we have chosen to improve early dementia diagnosis rates as one of our outcome metrics. This will improve the quality of people's lives by:

- Providing early dementia diagnosis, treatment and support in the community
- Providing intermediate care for older people with mental illness or dementia
- Improving the quality and effectiveness of inpatient care for older people with mental illness or dementia in general hospitals
- Improving the quality of long-term care

CCG	Risk Stratification	Estimated % at high risk of admission	Joint Care plan
East Surrey CCG	Docobo	Linked to contract with First Community and Proactive Care Team; initial identification of 250 people	As part of the First Community Contract, a specification is in place and been implemented to ensure patients at risk of admission are identified. A dedicated team (Proactive Care Team) are in place in the community whose primary role is to identify patients at risk using the Docobo Risk Stratification tool, liaise with the patient's GP and have in place a care plan to manage the patient. As part of the service, each member of the team is required to manage a specified number of patients.
Guildford and Waverley CCG	Risk assessment done at a local level/GP	Our focus is on those over 75 or with 3 or more conditions	We are using our £5 per head of GP population to support joint care planning and support for frail elderly people in our

	practice with MDT		population. During 2014/15 we aim to have care plans in place for 80% of end of life patients, with ambitions to put in place for those with cancer and COPD.
North East Hampshire and Farnham CCG	John Hopkins Adjusted Clinical Group (ACG)	The John Hopkins Adjusted Clinical Group's algorithms tool has been rolled out across GP practice populations. GPs have been incentivised to use data to predict high intensity users and stratify risk in relation to Long Term Conditions at risk of hospital admission. GP practices currently review the top 1% of their most at risk population each quarter	GP practices are implementing an agreed care plan for 10% of identified patients, co-ordinated through an accountable lead GP
North West Surrey CCG	Docobo	The CCG has identified that 0.16% of ther population has >75% risk of being admitted to hospital, this equates to 549 people	The Local Joint Commissioning Group 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
Surrey Downs CCG	John Hopkins Adjusted Clinical Group (ACG)	All registered patients are given a risk score from 0 to 99; GP practices determine which patients can be appropriately managed and the risk scores gives them guidance so it is difficult to define the number of patients that are classed at high risk as we do not choose a definite number threshold	
Surrey Heath CCG	Combined Predictive Model: still to agree own model	Combined predictive models suggest the top 0.5% of the population are 18.6% more likely to have an emergency admission than the average member of the population and up to 5% of the population are at "high risk" of an emergency admission	The Surrey Heath Health and Social Care Collaborative Forum confirm that people at high risk of hospital admission will have an accountable lead professional as part of a joint process to assess risk and plan care. We will undertake a baseline assessment of the proportion of individuals who currently have a joint care plan and lead professional

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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. Failure to accurately assess the financial impact of the introduction of the Care Bill in 2016	High	This risk cannot be entirely mitigated. Initial impact assessment underway. We will continue to refine assumptions in parallel with our Better Care Fund response.
2. Provider market in health and social care is insufficiently developed to support the future services required in the community	High	Develop market management strategy to support the local joint work programmes across Surrey
3. Scheduling of change is complex with risk of potential gaps if acute services are reduced before community capacity is in place	High	Transition planning and co-design critical. Close project management and pre-planned decommissioning schedules to underpin plan
4. Agencies are unable to change relationships, culture and behaviours	Medium	Strong leadership from the Surrey Better Care Board. Programme of change management interventions to support service transformation
5. Availability and capacity of the provider workforce to deliver the new model of care e.g. Community and Social Care workforce (staff numbers, competencies/skills, money).	Medium	Provider workforce capacity and contract plans will be an integral part of the planning process before a decision to implement.
6. Costs of the new system in health and social care exceeds return	Medium	Robust financial management arrangements are put in place
7. Improvement is not demonstrated against national and local metrics and performance element of the Better Care Fund is not secured	Medium	Ensure sufficient capacity and robust arrangements to monitor and report against national and local metrics as part of the governance arrangements
8. Insufficient engagement with patients, service users and the public, so future services do not meet the needs of the local community	Medium	Ensure sufficient capacity and expertise is made available to deliver a comprehensive communication and engagement plan
9. Insufficient leadership and/or operational capacity to deliver this major transformation change programme	Medium	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
10. Lack of improvement in the continuing healthcare process as part of the overall discharge pathway	Medium	Implement the programme of change arising from the recent review of continuing healthcare
11. Level and pace of discharge from hospital does not increase as required	Medium	Establish an integrated discharge network/model across services
12. People with dementia are left	Medium	Ensure best whole systems

unsupported		approach to care
13. Sharing of patient information between providers due to insufficient IT systems will impact deliverability of project outcomes	Medium	Providers to sign joint agreement for sharing free flow of information and patient data through secured network
14. Unplanned activity - A&E attendance and non-elective admissions - do not reduce at the level or pace required	Medium	Analyse required changes, joint planning and management of acute sector bed capacity reduction

8

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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	*18,309*	*5,327*	*5,327*
NHS East Surrey CCG	N		*9,397*	*9,397*
NHS Guildford & Waverley	N		*11,246*	*11,246*
NHS North West Surrey CCG	N		*19,808*	*19,808*
NHS Surrey Heath CCG	N		*5,501*	*5,501*
NHS Surrey Downs CCG	N		*16,398*	*16,398*
NHS North East Hampshire and Farnham CCG	N		*2,609*	*2,609*
Windsor, Ascot and Maidenhead CCG	N		*532*	*532*
BCF Total		**18,309**	**70,818**	**70,818**

** 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.*

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.

Rigorous procedures will be put in place to track the metrics leading to benefits and the associated spending trends. If there are signs that targets will not be achieved, reprioritisation will occur in year

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)	25	25
	Maximum support needed for other services (if targets not achieved)	25	25
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)	9	9
	Maximum support needed for other services (if targets not achieved)	9	9
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	10	10
	Maximum support needed for other services (if targets not achieved)	10	10
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	20	19
	Maximum support needed for other services (if targets not achieved)	20	19

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	2014/15 spend		2014/15 benefits*		2015/16 spend		2015/16 benefits**	
			Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
	New responsibilities under the Care Bill (Revenue)	SCC	0	0	0	0	2,563,000	0	0	0
	Capital Projects (including Disabled Facilities Grant)	SCC/Districts	0	0	0	0	5,327,378	0		
	Project Support	SCC	0	0	0	0	500,000	0	0	0
	Benefits to Health System				90,279				323,000	
	Protection for Adult Social Care				33,000	0			207,000	0
	Small Projects (up to 10% of BCF)		437,773				2,294,032			
			437,773	**0**	**123,279**	**0**	**10,684,410**	**0**	**530,000**	**0**
ES01	Optimising use of Acute Care Setting for Urgent Care through Pathway Redesign and Integrated Working		1,824,391				3,394,878			
ES02	Transforming Care and Care Settings through Pathway Redesign		410,050				612,050			
ES03	Parity of Esteem		133,212				178,712			
ES04	Promoting and Enhancing Quality of Life Through Self Management and Innovation		504,328				504,328			
ES05	Ensuring Delivery Through Appropriate Enablers		0				0			
	Benefits to Health System				1,542,281				5,518,000	
	Protection for Adult Social Care		0	0	574,000	0	0	0	3,588,000	0
ES Total			**2,871,981**	**0**	**2,116,281**	**0**	**4,689,968**	**0**	**9,106,000**	**0**
GW01	Primary Care Plus	Virgincare	700,000	0		0	1,200,000	0		0
GW02	Rapid Response	Virgincare	377,000	0		0	6,000,000	0		0
GW03	Telecare	Medivo	608,000	0		0	608,000	0		0
GW04	Virtual Wards	Virgincare	548,000	0		0	548,000	0		0
GW05	Social Care / Reablement / Carers	Surrey County Council	684,000	0		0	1,816,000	0		0
GW06	Mental Health	SABP	423,000	0		0	423,000	0		0
GW07	Other	Surrey County Council	298,000	0		0	651,000	0		0
	Benefits to Health System				1,850,570				6,621,000	
	Protection for Adult Social Care		0	0	686,000	0	0	0	4,288,000	0
GW Total			**3,638,000**	**0**	**2,536,570**	**0**	**11,246,000**	**0**	**10,909,000**	**0**
SD01	An enhanced, developed primary care service operating in networks of practices		1,000,000				3,902,000			
SD02	Ensure improved patient experience and outcomes within the continuing care assessment process through		338,000				1,446,000			
SD03	An Urgent Care and Discharge System that works to enable people to return home earlier in their recovery pathway		776,000				6,007,000			
SD04	Facilitate rapid discharge for those people with high risk of hospitalisation through a more responsive and effective Intermediate Care/Reablement teams.		2,398,000				3,570,000			
SD05	Integrated services to reduce admission (Enhanced Case Management)		508,000				1,473,000			
	Benefits to Health System				2,765,094				9,893,000	
	Protection for Adult Social Care				1,002,000				6,261,000	
SD Total			**5,020,000**	**0**	**3,767,094**	**0**	**16,398,000**	**0**	**16,154,000**	**0**
SH01	Admission Advoidance		101,000		20,000		3,260,000			
SH02	Rapid Discharge		180,000				450,000			
SH03	Nursing/residential home support		760,000				890,000			
SH04	Rehabilitation and Re- ablement		400,000				930,000			
SH05	Enabling services/structures		0							
	Benefits to Health System				913,406				3,268,000	
	Protection for Adult Social Care				336,000				2,100,000	0
SH Total			**1,441,000**	**0**	**1,269,406**	**0**	**5,530,000**	**0**	**5,368,000**	**0**
NEHF01	Carers		80,000				80,000			
NEHF02	Reablement		150,000				150,000			
NEHF03	Rehab Intergrated Pathway		100,000				100,000			
NEHF04	Mental Health		90,000				90,000			
NEHF05	Virtual Ward		50,000				50,000			
NEHF06	Fraility Integrated Pathway (including elements for CHC, equipment and social capital)		130,000				2,000,000			
	Benefits to Health System				425,679				1,523,000	
	Protection for Adult Social Care				159,000				993,000	0
NEFH Total			**600,000**	**0**	**584,679**	**0**	**2,470,000**	**0**	**2,516,000**	**0**
NW01	Integrated Frailty Pathway (incorporating end of life)		1,000,000				6,000,000			
NW02	Integrated Urgent Care Pathway		1,400,000				4,800,000			
NW03	Families, Friends and Communities (Including Carers)		1,900,000				4,000,000			
NW04	Integrated Primary Care						5,000,000			
	Benefits to Health System				3,317,945				11,871,000	
	Protection for Adult Social Care				1,210,000	0			7,563,000	
NW Total			**4,300,000**	**0**	**4,527,945**	**0**	**19,800,000**	**0**	**19,434,000**	**0**

Grand Total			**18,308,754**	**0**	**14,925,252**	**0**	**70,818,378**	**0**	**64,017,000**	**0**
	* Plans for 2014/15 incorporate ongoing projects from 2013/14: it is expected that these will generate benefits for health and for social care, but the detail behind that is yet to be finalised.									
	** 'Work is ongoing to generate the analysis of scheme-by-scheme benefits which will deliver the overall aspiration. This may lead to some adjustment to the investment proposals, including the possibility of setting aside some funding as necessary in order to ensure the £25m of additional benefit to protect social care spending									

18308754
0

70818378
0

Health Benefit	**10,905,252**	**39,017,000**
ASC Protection	**4,000,000**	**25,000,000**
		64,017,000
		64,017,000
		0.609478732

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 with membership from Surrey County Council and each Surrey CCG. The group will provide the necessary metric support to the local BCF coordination groups and report to the Surrey BCF Board.

Metric 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000. This metric will enable us to measure our success at identifying those at risk of incurring high health care costs, providing coordinated care to prevent people reaching crisis and our ability to provide 7 day coordinated care to enabled people to stay supported in their own homes for as long as possible, including timely discharge from hospital. Achieving success in this objective will have financial benefits as overall costs to health and social care will be lower. Current performance for this indicator in Surrey is good. Surrey in the 2nd best quintile nationally and ranked 38th lowest out of 152 local authorities for performance against this metric. Due to the uncertainty around effects of the Care Bill and to the increasing proportion of the ageing population, Surrey is seeking to maintain its current position. Currently for 2013/14, the figure is projected to be 1,177. This metric is measured using social care data sets.

Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 2: Proportion of older people who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services. This metric will enable us to measure our success at providing timely, high quality reablement services that are integrated with wider support services for people who have been admitted to hospital thus enabling people to stay at home for as long as possible. Surrey is in the lowest performing quintile nationally for this metric. This may be partly explained by under-reporting. In 2012/13 figures were under reported by approx 55%, which was due to recording issues around the first year submission of this data set.

Outcome: Ongoing sustained level of independence and recovery for people with long term health and care needs.

Metric 3: Delayed transfers of care from hospital

This metric will enable us to track progress on improving the interface between acute and community health and social care organisations. Surrey is currently a poor performer and is in the 4th quintile nationally (quintile 5 is the poorest performer).The Surrey BC Board agreed a statistically significant target of a 3.2% reduction of delayed transfers of care by June 2015.

Outcome: More individuals have their health and social care needs met in the most appropriate setting.

Metric 4: Avoidable emergency admissions
Emergency admissions can be clinically unnecessary, destabilising for the patient and costly to the system. By providing coordinated care in the community we hope to reduce the likelihood of conditions escalating so patients require admission and improve our capacity to provide appropriate care out of the hospital setting. Surrey currently has a low rate of avoidable emergency admissions and is aiming for a statisticaly significant improvement of 4.4% reduction by March 2015.
Outcome: Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home.

Metric 5: Patient / service user experience
We are awaiting national guidance for this metric, however we anticipate being able to quantify the parts of the health and social care system where satisfaction is not high and requires improvement.
Outcome: Improved satisfaction with health and social care services

Metric 6: Estimated diagnosis rate for people with dementia.
This local measure has been chosen as it has a clear demonstrable link to the Health and Wellbeing Strategy. Earlier diagnosis can mean appropriate treatment can be established for the patient and plans can be made with carers before the condition escalates. The Surrey BCF Board is aiming for the national target of a 66.7% diagnosis rate by 2015/16. Data is available on an annual basis from QoF data which is published at national level, however it is also available at GP and CCG level using the dementia calculator.
Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place.

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

The assurance process is the same for all the metrics. We are using five nationaly defined metrics and one locally defined metric (metric 6: dementia). The performance has been calculated by ananlyisng: historic trends, performance against comparator local authorities and nationally. This work is coordinated by a BCF metrics and finance group which reports to the Surrey BCF Board. It has representation from Surrey County Council and each CCG in Surrey.

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
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	568.2	N/A	568.2
	Numerator	1,155		1,221
	Denominator	203,275		214,918
		(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	77.1
	Numerator	225		243
	Denominator	315		315
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	258.0	254.0	249.8
	Numerator	21,054	20,933	13,866
	Denominator	906,631	915,816	925,149
		(Apr 2013 - Dec 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	123.4	121.0	118.0
	Numerator	17,178	8,513	8,393
	Denominator	1,159,940	1,172,608	1,185,259
		(Oct 2012 - Sep 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [National metric (under development) is to be used]			N/A	
Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	*Metric Value*	0.4	0.5	0.6
	Numerator	6,872	8,020	9,186
	Denominator	15,669	16,368	16,702
		(April 2011 - Mar 2012)	*(Apr 2014 - Sep 2014)*	*(Apr 2014 - Mar 2015)*