Notice of Meeting

Health and Wellbeing Board

Date & time
Thursday, 2 October 2014
at **1.00 pm**

Place
Committee Room C, County Hall, Kingston upon Thames, Surrey KT1 2DN

Contact
Huma Younis
Room 122, County Hall
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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 Andy Brooks (Co-Chairman)	Surrey Heath Clinical Commissioning Group
Councillor John Kingsbury	Woking Borough Council
Dr Joe McGilligan	East Surrey Clinical Commissioning Group
Dr David Eyre-Brook	Guildford and Waverley Clinical Commissioning Group
Dr Claire Fuller	Surrey Downs Clinical Commissioning Group
Dr Andy Whitfield	North East Hampshire and Farnham Clinical Commissioning Group
Dr Liz Lawn	North West Surrey Clinical Commissioning Group
Mrs Mary Angell	Cabinet Member for Children and Families
Councillor James Friend	Mole Valley District Council
Mr Mel Few	Cabinet Member for Adult Social Care
Peter Gordon	Healthwatch Surrey
Chief Constable Lynne Owens	Surrey Police
Helen Atkinson	Public Health
Nick Wilson	Director for Children, Schools and Families
John Jory	Reigate and Banstead Borough Council
Dave Sargeant	Interim Director 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: 4 SEPTEMBER 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 26 September 2014).*

4b Public Questions

The deadline for public questions is seven days before the meeting (*Thursday 25 September 2014)*.

4c Petitions

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

5 FORWARD WORK PLAN (Pages 9 - 12)

To consider the Board's Forward Work Programme and confirm the agenda for the next meeting on 6 November 2014.

6 UPDATE ON MENTAL HEALTH CRISIS CARE CONCORDAT (Pages 13 - 30)

This paper demonstrates the progress that has been made towards redesigning mental health crisis responses in Surrey as part of the Emotional Wellbeing and Mental Health plan which is one of the five Surrey Health and Wellbeing Strategy priorities.

7 ANNUAL PUBLIC HEALTH REPORT 2014 (Pages 31 - 32)

The purpose of the paper is to present Part 2 of the 2014 Annual Public Health Report (APHR).

(A copy of the APHR will be made available at the meeting)

8 JHWS PRIORITY UPDATE: IMPROVING CHILDREN'S HEALTH AND WELLBEING (Pages 33 - 44)

Following on from the meeting of the Health and Wellbeing Board on 13th March 2014, this report summarises progress against the aims and outcomes for improving children's health and wellbeing, 6 months on. It provides a detailed status update on delivery against the workstreams identified by Surrey Children and Young People's Partnership and commissioning priorities for the Children's Health and Wellbeing Group.

9 THE SURREY BETTER CARE FUND PLAN (Pages 45 - 216)

The purpose of this item is to formally note Surrey's Better Care Fund (BCF) plan following its submission to NHS England. Surrey's BCF plan **will be presented on the day** following the approval process agreed at the Health and Wellbeing Board on 4 September 2014.

THE SURREY BETTER CARE FUND PLAN IS NOW AVAILABLE TO VIEW

10 PUBLIC ENGAGEMENT SESSION

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: Tuesday 23 September

QUESTIONS, PETITIONS AND PROCEDURAL MATTERS

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

Please note:

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

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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

Anyone is permitted to film, record or take photographs at council meetings with the Chairman's consent. Please liaise with the council officer listed in the agenda prior to the start of the meeting so that the Chairman can grant permission and those attending the meeting can be made aware of any filming taking place.

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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 4 September 2014 at Old Council Chamber, Reigate & Banstead BC, Town Hall, Castlefield Road, Reigate, RH2 0SH.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 2 October 2014.

Elected Members:

* Mr Michael Gosling (Co-Chairman)
* Dr Andy Brooks (Co-Chairman)
  Dr Joe McGilligan
* Dr David Eyre-Brook
* Dr Claire Fuller
  Dr Andy Whitfield
* Dr Liz Lawn
* Mrs Mary Angell
* Councillor James Friend
* Mr Mel Few
* Peter Gordon
  Chief Constable Lynne Owens
* Helen Atkinson
  Nick Wilson
  Councillor John Kingsbury
* John Jory
* Dave Sargeant

In attendance

Sarah McBride, Director of Delivery, North East Hampshire and Farnham CCG

Fiona Harris, Head of Public Health (Area Team) NHS England

Dr Patrick Kerr, East Surrey CCG

45/14 APOLOGIES FOR ABSENCE [Item 1]

Apologies had been received from Andy Whitfield, Pennie Ford, Councillor John Kingsbury, Lynne Owens and Nick Wilson

Sarah McBride substituted for Andy Whitfield. Fiona Harris substituted for Pennie Ford and Patrick Kerr substituted for Joe McGilligan.

46/14 MINUTES OF PREVIOUS MEETING: 5 JUNE 2014 [Item 2]

The Chairman explained that any actions from the meeting would be recorded in the minutes with the initials of the individual responsible for taking these forward.

Resolved:

- That the minutes of the Health and Wellbeing Board held on 5 June 2014 be agreed as a correct record of the meeting.

47/14 DECLARATIONS OF INTEREST [Item 3]

There were none.

48/14 QUESTIONS AND PETITIONS [Item 4]

There were none.

(a) MEMBERS' QUESTIONS [Item 4a]
There were none.

49/14 PUBLIC QUESTIONS [Item 4b]

There were none.

50/14 PETITIONS [Item 4c]

There were none.

51/14 FORWARD WORK PROGRAMME [Item 5]

Key points raised during the discussion:

- The Chairman explained that some of the items scheduled for September's meeting had been rescheduled for October. An item on Surreys Crisis Care Concordat would be bought to the October meeting with an update item on promoting emotional wellbeing and

mental health being taken to the November health and wellbeing board meeting.

- A new item on the Better Care Fund and Integrated Whole Systems would also be taken to the October meeting.
- The Chairman explained that Cllr Joan Spiers had stepped down as a member of the board but thanked her for all her hard work during her time on the board.
- Councillor John Kingsbury had been nominated by District and Borough leaders to replace Councillor Joan Spiers as a member of the Board. Cllr Kingsbury who is the leader of Woking Borough Council was endorsed as a new member of the Health and Wellbeing Board.
- The Chairman explained that 'The Good Governance Institute' and 'Diabetes UK' had developed guidance for Health and Wellbeing Boards as system leaders on diabetes care and prevention. A survey would be undertaken by Public Health to understand what the board's priorities are in order to publish some more comprehensive guidance in relation to long-term conditions.

Resolved:

The Health and Wellbeing Board,

- Endorsed Cllr John Kingsbury as a new member of the Health and Wellbeing Board.

52/14 COMMISSIONING INTENTIONS & CYCLES [Item 6]

Witnesses:

Representatives of each CCG and the county council took it in turns to present the item.

Key points raised during the discussion:

1. A presentation sharing the commissioning planning timeframes and key commissioning priorities / intentions of each of the Clinical Commissioning Groups and Surrey County Council was presented.
2. A comment was raised around ensuring there were effective partnership working arrangements in place between the CCGs and the district and boroughs. A representative of the CCG's explained that a lot of work had been undertaken to ensure enough engagement had taken place with local boroughs.
3. The Board recognised that more could be done in relation to prevention.
4. In relation to substance misuse, a partnership group which discusses prevention had been set up. Dr Joe McGilligan represented the Health and Wellbeing board on this group. The Chairman explained that a great amount of work on prevention had been done and could be shared with the board in a future meeting.
5. Members of the Board commented on the benefits of integrating commissioning intentions and cycles. The Chief Executive of Reigate

and Banstead borough council stated that there was an opportunity to promote commissioning intentions and cycles to the district and boroughs and get their support with the delivery of these plans. The Chief Executive of Reigate and Banstead BC agreed to write to district and boroughs on this matter.

6. A member of the board commented on the need to ensure best working practices were shared as each CCG plan gets underway.

Resolved:

The Health and Wellbeing Board,

- Noted the presentation given by the representatives of the Clinical Commissioning Groups and Surrey County Council.
- Considered and discussed opportunities, gaps or challenges that had been identified in the presentation.

Actions/Next Steps:

The Chief Executive of Reigate and Banstead borough council to write to the district and boroughs and get their support with the delivery of commissioning intentions and plans. *John Jory*

53/14 BETTER CARE FUND UPDATE [Item 7]

Witnesses:

Dave Sargeant, Strategic Director for Adult Social Care

Key points raised during the discussion:

1. The BCF update note (Annex 1) was presented by the Strategic Director for Adult Social Care.
2. The Strategic Director for Adult Social Care explained that work on the BCF had driven partners to think about local better care plans more strategically. Better care plans would need to be resubmitted in late September with formal sign off (by the H&W Board) in early October.
3. It was explained that, given the national deadlines and the ongoing work being undertake to develop and finalise the better care fund plan for Surrey, there would be a tight turnaround in terms of sign-off of the plan – it was proposed that the better care fund plan would be circulated to the board for comment before submission in late September.
4. The metrics around BCF planning were queried with the board asking for a simpler version to be made available for the public. It was recognised that the metrics within Surrey would differ and that each CCG would have area specific rates they would aim to reduce.
5. A member of the board queried the difficulties that would be encountered when trying to reduce emergency admissions by 3.5%.

The Director for Public Health explained that work was already being done locally to reduce non elective admissions. CCG's carried a risk if this reduction was not met.

6. The Chairman of Healthwatch Surrey asked for a briefing on the BCF plan before submission of the plan in late September.
7. It was queried whether or not a draft copy of the BCF plans could be sent to members of the board. The Strategic Director for Adult Social Care explained that working documents were available but officers wanted to take a closer look into health and social care investment before sending out any plans.
8. It was explained that there had been a national pause on the BCF from April to July 2014. This had meant that additional work had to be done to ensure the plans were ready for submission in September.

Resolved:

The Health and Wellbeing Board,

- Noted the progress being made to develop Surrey's Better Care Fund plans

- Agreed the next steps for Surrey's Better Care Fund plan and agreed to receive a copy of the BCF plan for comment in September and formal sign off in October.

Actions/Next Steps:

For a copy of the better care fund plan to be circulated to the board for comment before submission in September.	*Dave Sargeant*
For the Chairman of Healthwatch Surrey to receive a briefing on the BCF plans before submission in September.	*Helen Atkinson*

54/14 AUTISM SELF ASSESSMENT [Item 8]

Witnesses:

Jo Poynter, Senior Manager in Commissioning, Adult Social Care

Key points raised during the discussion:

1. The board were given details of the Local Autism Self Assessment Framework which informs the Surrey Autism Strategy and the JSNA (presentation attached as Annex 1). The Health and Wellbeing Board were asked to oversee and monitor the outcomes. An update was also given on progress of Surrey's local action plan for Winterbourne View, following national guidance from the DH and LGA that Health and Wellbeing Boards have assurance that appropriate services are in place to meet the needs of any local people with learning disabilities.
2. With regards to the self assessment framework, it was explained that the service had details of how many children were diagnosed with

autism and also had a projection of autism numbers for the next 20 years.

3. The Senior Manager in Commissioning explained that the framework for self assessment started from 18+. A diagnostic service was in place to ensure services for people with autism were signposted.
4. Some members of the board felt there was disconnect between the work being done by the children and the adult's autism teams. The Director for Adult Social Care stated that the children and adults autism teams were actively working .
5. With regards to the Winterbourne update, the Senior Manager in Commissioning explained that bespoke services would have to be delivered for some of the individuals involved. Although the timeline has passed, work would be done to ensure that everybody leaving hospital would have a discharge plan and date arranged.

Resolved:

The Health and Wellbeing Board,

- Agreed to support the continued work of the Autism Partnership Board and action plan going forward.

Actions/Next Steps:

None

55/14 HEALTHWATCH SURREY [Item 9]

Witnesses:

Peter Gordon, Chairman, Healthwatch Surrey

Mike Rich, Chief Executive, Healthwatch Surrey

Key points raised during the discussion:

1. A presentation was given to the board on the Healthwatch Surrey Annual Report along with first year's activities and outcomes, plus headline objectives and plans for 2014/15 were also discussed.
2. A member of the board asked how data from hard to reach groups was collated. The Chief Executive for Healthwatch Surrey explained that records of where information was obtained from was recorded. Records showed that Healthwatch Surrey were underperforming on engagement with young people but were looking at innovative ways to increase engagement.
3. Healthwatch Surrey collated feedback on a quarterly basis but found that there needed to be an increase in follow ups.
4. The board agreed that sharing data between Healthwatch Surrey and CCG's would be beneficial and would allow for single data collection in the future.

5. A member of the board asked what was being done to engage with mental health patients. The Chief Executive of Healthwatch Surrey explained that this had now become a focus, feedback from the Citizens Advice Bureau (CAB) showed that 75% of the people accessing Healthwatch services through the CAB had a mental health issue. A project team would be put together in 2014/15 to look at this issue in detail.

Resolved:

The Health and Wellbeing Board,

- Commented and endorsed Healthwatch Surreys first year performance and achievements to date
- Supported the plans and activities for the current year.

Actions/Next Steps:

None

56/14 PUBLIC ENGAGEMENT SESSION [Item]

Key points raised during the discussion:

1. A member of the public reiterated the importance of partnership working across district and boroughs. The resident asked for an action arising from Item 6 , asking district and boroughs for their support with the Better Care Fund to be followed. It was also noted that there should be more joint working between public health, adult social care and CCG's on the prevention agenda; especially with the introduction of the Care Act 2014.

2. A member of the public asked what training was being given to school staff on mental health related issues. The Chairman stated that a great amount of training on mental health was being done with school staff. A member of the board stated that everybody should have the skills to deal with mental health issues and should be able to confidently signpost anyone affected.

Meeting ended at: 3.45pm

Chairman

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This forward plan is subject to ongoing review and may be amended depending on external events and Government policy

Forward Work Plan

2 October 2014 – Formal meeting in public

Item title:	**Update on the Mental Health Crisis Care Concordat**
H&W Board champion(s):	**Andy Whitfield, Dave Sargeant, Mel Few**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

Item title:	**JHWS priority update: Improving children's health and wellbeing**
H&W Board champion(s):	**Nick Wilson, David Eyre-Brook, Mary Angell**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

Item title:	**Director of Public Health Annual Report**
H&W Board champion(s):	**Helen Atkinson**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

Item title:	**Better Care Programme**
H&W Board champion(s):	**Andy Brooks, Dave Sargeant**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

6 November 2014 – Formal meeting in public

Item title:	**JHWS priority update: Promoting emotional wellbeing & mental health**
H&W Board champion(s):	**Andy Whitfield, Dave Sargeant, Mel Few**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

Item title:	**Update on the joint commissioning strategy for children's emotional wellbeing and mental health**
H&W Board champion(s):	**Nick Wilson, David Eyre-Brook**
H&W will be asked to:	**Note / discuss progress; and** **Endorse the next steps.**

11 December 2014 – Formal meeting in public

Item title:	**Surrey Safeguarding Children and Adults Board's Annual report**
H&W Board champion(s):	**Mary Angell, Mel Few, Nick Wilson, Dave Sargeant**

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H&W will be asked to:	**Discuss the recommendations from the Surrey Safeguarding Children and Adults Board's Annual Reports; and Consider implications for H&W Board member organisations.**

Item title:	**JHWS priority update: Improving older adults health and wellbeing**
H&W Board champion(s):	**Dave Sargeant, Liz Lawn, Mel Few**
H&W will be asked to:	**Note / discuss progress; and Endorse the next steps.**

Item title:	**Sharing forecast budget positions**
H&W Board champion(s):	**Michael Gosling, Andy Brooks**
H&W will be asked to:	**Discuss forecast budget positions; and Identify opportunities, challenges and implications.**

8 January 2015 – Informal meeting

5 February 2015 – Informal meeting

12 March 2015 – Formal meeting in public

Item title:	**Better Care Programme update**
H&W Board champion(s):	**Andy Brooks, Dave Sargeant**
H&W will be asked to:	**Note / discuss progress; and Endorse the next steps.**

Item title:	**Pharmaceutical Needs Assessment**
H&W Board champion(s):	**Helen Atkinson, Michael Gosling**
H&W will be asked to:	**Approve Surrey's Pharmaceutical Needs Assessment**

Item title:	**District and Borough Strategic Plan Wellbeing Assessments**
H&W Board champion(s):	**James Friend, John Jory**
H&W will be asked to:	**To discuss the alignment of the strategic plans of Surrey's District and Borough Councils with Surrey's Joint H&W Strategy**

Item title:	**JHWS priority: Developing a preventative approach – phase two**
H&W Board champion(s):	**Helen Atkinson, John Jory, Michael Gosling**
H&W will be asked to:	**To be determined at the 11 December informal meeting**

Item title:	**Clinical Commissioning Groupss' Quality Measures and Annual Reports**
H&W Board champion(s):	**Andy Brooks**
H&W will be asked to:	**Approve the approach to developing and signing off the Clinical Commissioning Groups' Operations Plan Quality Premium Measures;**

	Approve the approach for the Board's consultation on Clinical Commissioning Group Annua

2 April 2015 – Event (TBC)

Item title:	**Childhood obesity event**
H&W Board champion(s):	**Helen Atkinson, James Friend, Claire Fuller, Nick Wilson**
H&W will be asked to:	

May 2015 – No meeting

11 June 2015 – Formal meeting in public

Item title:	**Commissioning Strategies & Strategic Plans**
H&W Board champion(s):	**Michael Gosling, Andy Brooks**
H&W will be asked to:	**Discuss commissioning plans;** **Identify opportunities and challenges;** **Provide comments / feedback re. alignment of all commissioning plans with Surrey's Joint H&W Strategy.**

11 June 2015 – Informal meeting

2 July 2015 – Informal meeting

August 2015 – No meeting

3 September 2015 – Formal meeting in public

Item title:	**Commissioning intentions and cycles**
H&W Board champion(s):	**Michael Gosling, Andy Brooks**
H&W will be asked to:	**Discuss commissioning intentions and cycles;** **Identify opportunities and challenges; and** **Assure itself of alignment of all commissioning intentions with Surrey's Joint H&W Strategy.**

Item title:	**Beyond the Better Care Programme**
H&W Board champion(s):	**Andy Brooks, Dave Sargeant**
H&W will be asked to:	**Discuss and consider the next phase of health and social care integration.**

1 October 2015 – Informal meeting

This forward plan is subject to ongoing review and may be amended depending on external events and Government policy

5 November 2015 – Informal meeting

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10 December 2015 – Formal meeting in public

Item title:	**Surrey Safeguarding Children and Adults Board's Annual report**
H&W Board champion(s):	**Mary Angell, Mel Few, Nick Wilson, Dave Sargeant**
H&W will be asked to:	**Discuss the recommendations from the Surrey Safeguarding Children and Adults Board's Annual Reports; and** **Consider implications for H&W Board member organisations.**

Item title:	**Sharing forecast budget positions**
H&W Board champion(s):	**Michael Gosling, Andy Brooks**
H&W will be asked to:	**Discuss forecast budget positions; and** **Identify opportunities, challenges and implications.**

Health and Wellbeing Surrey

Surrey Health and Wellbeing Board

Date of meeting	2 October 2014

Item / paper title: Update on Mental Health Crisis Care Concordat

Purpose of item / paper	This paper demonstrates the progress that has been made towards redesigning mental health crisis responses in Surrey as part of the Emotional Wellbeing and Mental Health plan which is one of the five Surrey Health and Wellbeing Strategy priorities.
Surrey Health and Wellbeing priority(ies) supported by this item / paper	Emotional Wellbeing and Mental Health priority.
Financial implications - confirmation that any financial implications have been included within the paper	This 2 year redesign will be achieved within existing resources across the public agencies in Surrey. A public sector transformation bid has been submitted to the department for communities and local government for 2015/2016 which if successful will pump prime the service redesign and deliver efficiencies across agencies over the next 10 years. The public service transformation bid was submitted to aid the acceleration of the redesign of current services consistent with our action plan as well as identifying system wide efficiencies over the next 10 years. If the bid is unsuccessful it will not have a finance impact on the commitment to redesign existing services as we were clear from the outset that these changes would be delivered within existing resources and would not affect individual agency efficiency targets.
Consultation / public involvement – activity taken or planned	We have carried out extensive engagement with stakeholders which identified the 5 priority areas of the Emotional Mental Health & Wellbeing Strategy which is currently out for public consultation which ends on the 28 September 2014.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	Equality and diversity implications have been addressed and an equality impact assessment has been carried out as part of the establishment of the Emotional Mental Health and Wellbeing Strategy.

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Report author and contact details	Donal Hegarty, Senior Manager Commissioning, Adult Social Care, Surrey County Council Donal.hegarty@surreycc.gov.uk 01483 517944 Diane Woods, Associate Director Commissioning Mental Health and Learning Disability, North East Hampshire and Farnham Clinical Commissioning Group Diane.woods@hampshire.nhs.uk 07912774656
Sponsoring Surrey Health and Wellbeing Board Member	Dr Andy Whitfield, Chair North East Hampshire and Farnham CCG David Sargeant, Strategic Director, Adult Social Care Mel Few, Cabinet Member for Adult Social Care
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** a) Support the action plan of the Crisis Concordat Delivery Group b) Note the progress that has been made since we presented this proposal to the board on the 6 June 2014 c) Advise on the agency sign up to the Surrey crisis care concordat statement d) A report will be brought to the Health & Wellbeing Board on 11 December 2014 with further update on progress.

Health and Wellbeing Board
2 October 2014

Update on Mental Health Crisis Care Concordat

Purpose of the report:
This report details the progress made on the implementation of the Surrey Crisis Care Concordat following an implementation proposal presentation to the Board at its meeting on 5 June 2014.

Introduction:

1. The National Crisis Care Concordat was published in February 2014 which set out principles and actions which would improve the outcomes for people experiencing mental health crisis.

1.1. It identified four strategic areas where public services should work together to deliver a high quality response when people of all ages with mental health problems urgently need help. The strategic areas are:

- **Access to support before the crisis point**
- **Urgent and emergency access to crisis care**
- **The right quality of treatment and care when in crisis**
- **Recovery and staying well and preventing future crisis**

1.2. In May 2014 key stakeholders and representatives of the public services in Surrey agreed a Surrey crisis care concordat statement with the following commitment:

- **A clear agreement to work together to improve the mental health crisis**
- **The delivery of a universal single point of access for acute mental health crisis with appropriate clinical responses consistent with the presenting problem**
- **The establishment of local 'safe havens' in the districts/boroughs where individuals can receive support and assessment for their presenting crisis**
- **The establishment of a single spine for information to be integrated and shared which will be lead by the emergency services collaborative partnership**

1.3. A presentation of how the concordat would be implemented was given to the Board at its meeting on 5 June 2014.

Crisis Care Concordat Delivery Group

2. A crisis care concordat delivery group was set up to identify an action plan which would drive the redesign of current services and ensure that the outcomes were consistent with the Surrey concordat statement.

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2.1. The service delivery group is led by senior representatives from North East Hampshire & Farnham CCG and has representatives from Surrey Police, Surrey and Borders Partnership NHS Foundation Trust, Surrey County Council, South East Coast Ambulance Service and service users and carers. The group have had meetings to date in July, August and September 2014 where it developed a comprehensive action plan ensuring that all areas such as substance misuse, children's, advocacy and prevention strategies are being addressed and have been agreed by all parties attached as Appendix 1.

Progress to date

3. Since the crisis care concordat delivery group has been set up the commitment to change has been a visible feature of our work and in particular the Police and Surrey and Borders Partnership NHS Foundation Trust have focused on improving existing practices ensuring their is a governance structure where operational issues can be escalated up to deliver consistent outcomes.

3.1. It has been agreed that the current police liaison group morphs into the mental health delivery group which will meet monthly and Surrey and Borders Partnership NHS Foundation Trust are setting up a practitioner group by the end of September 2014 that will ensure there are escalation processes for unresolved issues.

3.2. Other areas where operational improvement has been made between Surrey and Borders Partnership NHS Foundation Trust and Surrey Police are:

- **Surrey Police & Surrey and Borders Partnership NHS Foundation Trust to introduce a better vulnerability assessment tool**
- **Pilot Surrey and Borders Partnership NHS Foundation Trust staff within police control room environment for immediate access to Surrey and Borders Partnership NHS Foundation Trust systems ensuring the best development decisions are made**
- **Surrey and Borders Partnership NHS Foundation Trust are reviewing their search policy in conjunction with Surrey police to ensure that both Surrey and Borders Partnership NHS Foundation Trust/police are clear on roles and requirements.**
- **Commitment by ward staff in Surrey and Borders Partnership NHS Foundation Trust and police officers to understand that**

they are committed to a joint resolution of presenting crisis and not focusing on single agency priority to off load the problem.

- **Better handover from police to a place of safety where an additional bed has recently been opened in the Abraham Cowley Unit**
- **Update of current protocols, particularly the transport protocol which is identified as a priority discussion with South East Coast Ambulance Service**
- **Positive discussions with A&E departments in the 5 acute hospitals to develop protocols around how individuals in mental health crisis are managed with the A&E environment**
- **Recognition that the joint data sets are poor and agreement on gathering information on section 136 and people in police custody.**

3.3. Through a focus of improving practice between the Police and Surrey & Borders staff there has been a significant reduction of people with mental health problems detained under section 136 held in police custody. We had been operating at between 14% - 19% but this is now around 5% and we have aspirations to reduce this aspect of detention under section 136 to 0%.

Signing the Surrey Crisis Care Concordat

4. We have reviewed the wording of the Surrey Crisis Care Concordat statement following discussions with stakeholders and would like to propose local public sector agency sign up to the concordat demonstrating the collective commitment to improving crisis services in Surrey.

Working with the Voluntary Sector

5. We have had discussions with voluntary sector organisations to canvas innovative models of ‘safe havens’ in local district and boroughs where individuals can be directed to and supported when in crisis as alternative to A&E departments.

5.1. As part of our commitment to establishing a whole systems approach to responding to crisis we see the voluntary sector as a partner in responding to social crisis which should have a preventative impact in stopping presenting crisis escalating into acute crisis. We are asking the voluntary sector to deliver ‘safe havens’ as part of our whole systems approach.

5.2. The establishment of ‘safe havens’ are being informed by the learning and principles taken from the Aldershot ‘café’ pilot, which has been recently positively evaluated. Surrey and Borders Partnership NHS Foundation Trust will remain the lead provider for acute mental health crisis however an innovative approach to delivery of the crisis line is being developed with the voluntary sector as potential partners to SABP as part of a whole systems approach to crisis management.

Profiling Crisis need in Surrey

6. Mental health strategies have been employed to carry out a simulation modelling exercise which will identify the potential impact that pathway changes could make across the system and will inform recommendations about what our redesign model should look like, assuring us on a safe number of beds

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6.1. The work will commence in October 2014 and report in February 2015 which should give us evidence based data which will inform our redesign plans of current services.

Capturing the Experience of Service Users and Carers

7. We want a new redesign of mental health emergency/ crisis services to be informed by the experience of people who use the services and their carers. This will be captured through the involvement workshop on crisis and the Surrey and Borders Partnership NHS Foundation Trust acute service review work.

Conclusions:

8. Since this programme was launched in July 2014 there has been a priority focus to improve existing practices, establish a multi agency delivery group, agree multi agency action plan which will deliver the aims of the Surrey concordat and scope the size of the challenge in Surrey. We have achieved 'quick wins' which will improve multi agency practice and are sighted on delivering the action plans over the next 2 years.

Recommendations:

9. The Board is asked to:

   a) Support the action plan of the Crisis Concordat Delivery Group
   b) Note the progress that has been made since we presented this proposal to the board on the 5 June 2014
   c) Advise on the agency sign up to the Surrey crisis care concordat statement
   d) A report will be brought to the Health & Wellbeing Board on 11 December 2014 with further update on progress.

Next steps:

10. The crisis care concordat delivery group will meet monthly and focus on delivering the agreed action plan.

10.1. We will pursue the submission of the public service transformation bid for 2015.

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Sources/background papers:
National Crisis Care Concordat February 2014
Surrey Police Peer Review

Appendix 1

CCC Action plan updated Sept14 for H

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Surrey Declaration & Action Plan to the Mental Health Crisis Care Concordat

Surrey mental health crisis care concordat:

our joint declaration

'We commit to work together in Surrey to improve the system of care and support so all people and their families in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances and time of day or night in which they first need help – and from which ever service they turn to first.

We will work together to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations.

We will strive to make sure that all relevant public services offer high quality support to someone who appears to have a mental health problem to help move towards recovery.

Jointly, we hold ourselves accountable to enable this commitment to be delivered across Surrey'.

Surrey Mental Health Crisis Care Concordat

– DRAFT v1 Action Plan to enable delivery of shared goals

6

Commissioning to allow earlier intervention and responsive crisis services				
No	**Action**	**Timescale**	**Led By**	**Outcomes**
GOVERNANCE				
1	**Delivery group** established - meet monthly to oversee the action plan and ensure delivery	July 2014	CCG	Transformation of local services
2	**Sign off** declaration/action plan	September 2014	Delivery Group	Commitment given by all agencies to deliver
3	**Practitioner group** established reporting to the strategic delivery group where operational issues can be escalated for resolution	September 2014	SABP	Ensure there are escalation processes for unresolved issues
4	**Joint SI & Safeguarding Learning -**Triangulation of different agencies MH SI/SafeG reporting and review processes	June 2015	Delivery Group	Shared learning from SI's to improve future practice
4a	**Review of safeguarding in all substance misuse contracts/providers**	End Sept	Public Health- Catherine Croucher	Commissioners are assured of the safeguarding capabilities of substance misuse service providers
5	**Outcome Metrics -** An agreed joint data set to establish baseline and capture demand and responses for people in mental health crisis (SABP, EDT, Police, 136, Ambulance, A&E's, 111)	July 2014	NHSE & Delivery Group	Clearer evidence and a focus on outcomes on which to base local commissioning and ensure inequalities addressed
6a	Clarify with Police toolkit and definition around intoxication in relation to 136	Sept 14	DAT- Martyn Munroe	Define if data capture will be on presenting intoxication or 'history' to better understand needs
RESOURCE				
6	**Right Level of Beds** Commission Mental Health Strategies to complete simulation modelling on Surrey MH Crisis model to meet needs	July – Dec 2014	CCG	Least restrictive most local and effective response to crises. Prevention of out of area and custody placements

6a	Need to ensure that CAMHS beds and pathway is included in approach and consideration understood as to any impact.	End Oct	CAMHS Diane McCormack	Simulation modelling is for Adult services but need to understand any potential impact
7	**Gap Analysis** Analysis of gap between current provision and concordat vision to inform actions	September 14	NHSE & Delivery Group	Focus commissioning support programmes on areas needing improvement
CONSISTENT RESPONSE				
8	**Joint protocols** Develop and agree local standards and protocols being clear for each partner agency response times, roles and responsibilities	March 2015	Transport SECAMB A&E – Acutes MisperPolice Restraint and Search-SABP	
8a	**sign off current reviewed protocols from all agencies**	End August 14	All agencies/practitioner group	Understand if protocols are already in place and if they are being applied at the ground level
9	**Training** a) Joint Training developed b) delivered to increase mental health awareness and inform about local standards and protocols for frontline emergency service responders	Pack developed April – June 2015 Delivered July 2015 – March 2016	Joint Training Group	Staff are equipped to treat mental and physical conditions with equal priority
9a	Public Health enters mobilisation for a new Tier 3 and 4 provider for substance misuse Oct 2014 as part of which **an operation guidance document will be produced**	Oct 2014	DAT- Martyn Munroe	To provide clear, updated guidance to promote commissioning practice in line with concordat expectations.

Access to support before crisis point: – ***"know who to contact at any time, 24 hours a day, seven days a week"***				
No	**Action**	**Timescale**	**Led By**	**Outcomes**
10	Primary care support on early identification of mental health issues and referral points	Nov 14	CCG's	Early identification and crisis prevention

10a	Identified primary care development measures within the "quality and innovation" measures in DAT contracts (similar to CQUIN) scheduled for 2015/16 Further opportunities are available to pick this up under "quality and innovation" measure and within the operational guidance.	Plan Development Q3 and Q4 14/15 delivery synchronised engagement with GP practices Q1-Q4 2015-16	DAT-Martyn Munroe	Prevention of avoidable crises.
11	Development of local planning for integrated community hubs inclusive of mental health and responding to inequalities in access to services and aligning MH hours of service to those in primary car	CCG specific through 15/16	CCG's	Improved outcomes and experiences of people with mental health needs accessing services meeting their whole needs and ensure services take account of the needs of diverse local populations when improvements are made
12	Development of voluntary sector at a local level to provide peer and carer support services such as buddying and safe havens in each locality	April – June 2015	SCC/CCGs	Improved community response should have impact on improving service user and carer experience being able to reduce usage of in-patient facilities in mental health and acute hospital presentation.
13	Suicide prevention work: emerging priorities are: suicide awareness skills training, suicide audit and self-harm These will be worked into actions Sept/Oct 14	15/16	Public Health-Catherine Croucher	To reduce the number of suicides and attempted suicides across Surrey.

Urgent and emergency access to crisis care: – ***"treated with as much urgency and respect as if it were a physical health emergency, travel safely in suitable transport to where the right help is available"***				
No	**Action**	**Timescale**	**Led By**	**Outcomes**
DEVELOPING SINGLE POINT OF ACCESS: Public Facing (111 & 999)				
14	Call handling / dispatch a) Surrey Police introduce a better vulnerability assessment when incidents/calls are	by Sept 14	Police / SABP	This would be a really symbolic approach and should assist in preventing individuals entering the system when they're in crisis.

	received. This will be developed jointly with SABP b) Pilot SABP staff within police control room environment for immediate access to SABP systems to ensure the best deployment decisions are made c) Pilot for then using that joint-call handling function to deploy the most appropriate asset – police, SABP staff etc., dependent on need			
DEVELOPING SINGLE POINT OF ACCESS: Specialist MH Facing (SABP)				
15	Establish a 24 hour mental health crisis universal single point of access:	April 2015	SABP	Culture change that will ensure appropriate response based on professional assessment and triage
16	- Agree a SPA model that is universal and integrated with Voluntary sector and 111/999 services	November 2014	Delivery Group	Mental health will receive the same response as people with a physical health crisis would rceive
17	- SABP to develop partnership with voluntary sector on the running of the crisis line that will be an integrated part of the SPA.	Dec 14 – Mar 15.	SABP	Voluntary sector involved in delivery crisis line within a whole systems response offering increased capacity, wider access to the public, less stigma and value for money.
18	- Closer working arrangements between SABP, 111 and 999 for mental	November 2014	SABP	Efficiencies to all agencies consistent with a seamless service response.

	health crisis and prevention agreed			Mental Health receiving parity of esteem to physical health
19	- Co-location with 111 / 999	April 2015	111/partners	To support single point of access pathway
20	- Identify and procure supporting IT and telephony systems	Dec 14 – Mar 15	SABP	IT and telephony will facilitate call handling for the single point of access – these will facilitate quicker response; less duplications and hand-offs between services offering efficiencies, increased capacity and safer services
Crisis / Emergency Response				
21	Enhanced HTT	15/16 & 16/17	SABP	More capacity for swift response/informing choice/home treatment especially OOH
22	Integrated working protocols with HTT/Substance Misuse/CAMHs/Criminal Justice teams/LD	Sept 14- Feb 15	SABP/DAT/CAMHS/Police	Better communication and interagency working between community mental health teams and others Least restrictive, most local and effective response to crises.
22 a	MH & Substance misuse commissioners to ensure that liaison and diversion services refer individuals with a co-existing MH and SM problems into appropriate services which can address their needs.	15/16	DAT	The needs of services users with co-existing mental health and substance misuse needs are better addressed in the development of services
23	Ensure there are adequate **liaison psychiatry** services in Emergency Departments	September 2014	NHSE/RCP/CEM	Parity of urgent access standards for people experiencing MH Crises
23a	Establish baseline for	15/16	NHSE/RCP/CEM	

	parity of urgent access standards for people experiencing MH Crises			
24	Review arrangements for out of hours AMHP provision	March 2015	SCC/SABP	Reduction in delays experienced awaiting AMHP assessment
Young Persons- 25				

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Quality of treatment and care when in crisis:-

"I am treated with respect and care and receive support and treatment, without unnecessary assessments, from people who have the right skills in a setting that suits my needs. Staff check any relevant information about me and, as far as possible, they follow my wishes and any plan I have voluntarily agreed to. If I have to be held physically this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing. Those closest to me are informed about my whereabouts and timely arrangements are made to look after any people or animals that depend on me."

No	Action	Timescale	Led By	Outcomes
26	An **integrated information** spine for crisis care plan information to be available across agencies	November 2015	ECP Group	Prevent people escalating further in their crisis; ensure individuals preferences and their contingencies in their care plan are known and acted on where possible. This could avoid conveyance to A&E when not appropriate and reduce use of section 136, EDT and AMHPs.
27	**Urgent review/relaunch of Missing Persons/Absconders** and Welfare Check protocols as current protocols place requirement on staff and police that are not being complied with.	September / October 2014	Police/SABP	Protect those who are going missing.
28	**Review Repeat Venues for absconcion** – joint assessment of top 3 venues to agree action plan to reduce absconders etc.	July – Aug 2014	SABP (police can assist)	Prevent future absconcion
29	**Police Arrests/Custody** - Better handovers from police to place of safety, detailing circumstances a) 3hr assessment time	Sept 14	Police SABP	

	limit (our protocols currently say 4hrs) b) Develop information sharing with police when S136 assessment beds are full (ie surge times), so that custody suites/police can be 'made ready'		SABP	
30	**Restraint, Searching, Police attendance at MH wards etc**. - Review and development of current SABP search policy, SABP/Police to jointly agree each agencies roles/requirements a) Ensure agreement is reached and policy is clear on when Police will be called (ie crime committed) rather than heavy police involvement for a crisis that could be managed by staff b) Positive Police action when called to criminal matters	Sept 14	SABP/Police	To have a joint policy that reinforces this is a joint resolution
31	Advocate access	April 2015	SCC	Improving access to advocacy for people in MH crises. Potential to explore s135/136 access to advocacy as a specific action.
32	Accessible info on services and standards	Nov 15	SCC/CCG	
33	Transitions standards			
34	Environment standards in A&E - Audit of MH assessment rooms in A&E	During 2014	CEM through the PLAN accreditation network	Service Users experience a safe and improved environment and staff safety is improved
35	Review agencies protocols on restraints to ensure in line with national guidance	Nov 14	Delivery Group	Part of a wider programme to reduce the use of physical restraint in mental health
36	Develop resources to support safeguarding boards, specific to the circumstances and	Dec 2014	SCC/ADASS	Ensure effective planning and monitoring and review of local safeguarding

	needs of, and responses to, people experiencing mental health crisis			arrangements.

Recovery and staying well / preventing future crises:-

"I am given information, and referrals about services that will support my recovery. I am supported to reflect on the crisis and develop a plan for how I wish to be treated if I experience a crisis in the future. I am offered an opportunity to feedback to services my views on my crisis experience."

No	Action	Timescale	Led By	Outcomes
37	Repeat presentation prevention planning	15/16	SABP Primary care	
38	Standards set for the use of care plans and contingency planning	15/16	SABP	Service users jointly produce contingency plans in case of relapse or crisis
39	To the attention of Health and Social Care services vulnerable people identified in the course of the day to day policing	Ongoing	Police	Prevention of crisis due to relapse in poor MH experienced by a vulnerable person
40	Liaison and diversion services refer individuals with co-existing mental health and substance misuse problems to services which can address their needs	15/16	SABP	The needs of service users with co-existing mental health and substance misuse needs are better addressed in the development of services

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Health and Wellbeing Surrey

Surrey Health and Wellbeing Board

Date of meeting	2 October 2014

Item / paper title: Director of Public Health Annual Report – Part 2

Purpose of item / paper	The purpose of the paper is to present Part 2 of the 2014 Annual Public Health Report (APHR).
Surrey Health and Wellbeing priority(ies) supported by this item / paper	The paper outlines the focus of the APHR Parts 1 & 2 which this year has focused on Prevention, one of our 5 HWB priorities. Part 1 was published in May of this year and focused on the greatest behavioural risk factors for ill health and early death - smoking, lack of physical activity, poor diet and alcohol misuse. The prevention theme continues in Part 2 of this year's report which focuses on preventing harm from poor air quality, excess seasonal mortality and unintentional injuries. The evidence for focusing on prevention is substantial and well described in both reports.
Financial implications - confirmation that any financial implications have been included within the paper	There are no specific financial implications from the APHR, however there will be financial implications for the delivery of the Prevention Priority Plan that is being developed concurrently and will be presented at the March 2015 meeting of the Board.
Consultation / public involvement – activity taken or planned	Partner's engagement took place as part of the development of the APHR (Part 1 & 2). This led to partnership case studies being included in the reports to highlight key areas of work already being delivered on the prevention agenda locally.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	The focus of the APHR is on preventing ill health and early death by targeting health inequalities. Therefore tackling equality and diversity implications are at the heart of the report.
Report author and contact details	Helen Atkinson: Director of Public Health, Surrey County Council - Helen.atkinson@surreycc.gov.uk
Sponsoring Surrey Health and Wellbeing	Helen Atkinson: Director of Public Health, Surrey County Council - Helen.atkinson@surreycc.gov.uk Councillor Michael Gosling: Cabinet Member for Public

Board Member	Health & Health & Wellbeing Board, Surrey County Council – Michael.gosling@surreycc.gov.uk
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** • Endorse the findings from the APHR and support the recommendations being included in the development of the Prevention Priority Plan. • Agree to a further Prevention item being brought to the board in June 2015. • Agree to receive further APHR at the Board in future years.

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Surrey Health and Wellbeing Board

Date of meeting	2 October 2014

Item / paper title: Children's Health and Wellbeing – status update

Purpose of item / paper	Following on from the meeting of the Health and Wellbeing Board on 13th March 2014, this report summarises progress against the aims and outcomes for improving children's health and wellbeing, 6 months on. It provides a detailed status update on delivery against the workstreams identified by Surrey Children and Young People's Partnership and commissioning priorities for the Children's Health and Wellbeing Group. Whilst many outcome measures are still in development, this status update provides some key differences to CYP and families of the work that is ongoing.
Surrey Health and Wellbeing priority(ies) supported by this item / paper	Surrey's Joint Health and Wellbeing Strategy (JHWS) commits to five priorities: 1. Improving children's health and wellbeing 2. Developing a preventative approach 3. Promoting emotional wellbeing and mental health 4. Improving older adults' health and wellbeing 5. Safeguarding the population This status update sets out how the priority for improving children's health and wellbeing is being delivered. It reports on the priorities identified by the Surrey Children and Young People's Partnership and Children's Health and Wellbeing Group for 2014/15 (as set out in the Surrey Children and Young People's Plan 2014-17): ○ **Early help** which includes healthy behaviours ○ **Complex needs** which includes paediatric therapies ○ **Emotional wellbeing and mental health** ○ **Safeguarding** which includes domestic abuse and improving health outcomes for looked after children ○ A key enabler that supports these priorities is developing a **shared understanding of need**
Financial implications - confirmation that any financial implications have been included within the paper	This status update report on the priorities will help shape the collective spend on children and young people's health and wellbeing of the following organisations: Surrey County Council, Clinical Commissioning Groups, Police and District and Borough Councils. This includes £325m Children, Schools and Families

	(not including schools) and £23m (Public Health total budget)
Consultation / public involvement – activity taken or planned	The priority setting and status update has been informed by extensive public consultation on the Health and Wellbeing Strategy and needs analysis including service user experiences. Actions have been developed through workshops and meetings with the Health and Wellbeing Board, Surrey Children and Young People's Partnership and Children's Health and Wellbeing Group. The detail of delivery will continue to be further shaped by engagement with wider stakeholders for each action and further co-production with service users where appropriate.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	The analysis of need that informed that priorities in the Surrey Children and Young People's Plan 2014-17 systematically identifies inequalities in health and wellbeing. The priorities and actions for 2014/15 were developed to help to mitigate those inequalities. For example through our approach to supporting children with complex needs, targeting interventions to promote healthy behaviours, tackling the causes of poorer outcomes for children which can include parental issues such as substance misuse and domestic abuse.
Report author and contact details	Andrew Evans – Strategy and Policy Development Officer, andrew.evans@Surreycc.gov.uk, 01372 833992
Sponsoring Surrey Health and Wellbeing Board Member	Nick Wilson, David Eyre-Brooke
Relevant portfolio holder	Councillor Mary Angell
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** a) note the progress and successes towards actions to improve children's health and wellbeing. b) consider a further progress report in 6 months.

Improving Children and Young People's Health and Wellbeing

Priority status update 2 October 2014

Performance scorecard

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Children and Young People's Plan – strategic priorities	RAG Rating
Early Help (including healthy behaviours)	A
Complex Needs (including paediatric therapies)	A
Emotional wellbeing and mental health	A
Safeguarding (including domestic abuse and improving the health outcomes of LAC)	A
Shared understanding of need	G

- This is the first time we have reported our performance against the partnership priorities using a RAG rating system.

- The following presentation will give an overview of our current position and next steps. It will also highlight some of the key differences this is making to children, young people and families.

Early Help (including healthy behaviours)

Aim: To identify and address the needs of Surrey's children and families earlier, reducing the need for more intensive, acute or specialist support.

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

EARLY HELP

Current position

- EH Commissioning action plan agreed by EH commissioning group. Robust contract monitoring of grant funded Early Help services with outcome focussed service specifications.
- Roll out of Early Help assessment among all agencies. Analysis of assessments from April 2012 to inform commissioning.
- Early Help area conferences have improved understanding of working together, lead professional role and team around the family meetings. Increased uptake of Early Help and Lead Professional training within multi-agencies.
- New Early Help web pages available
- EH Champion partnership event in September 2014.
- Preparation for Phase 2 of Troubled Families Programme focusing on integrated partnership working
- Concept of early help is being picked up in the strategy for paediatric therapies

Risks and issues for escalation

- Engagement with all partners, particularly schools, is key to success. This is being addressed through review of governance and consulting on outcomes framework.

Next steps

- Develop and consult on outcomes framework that will define success measures for Early Help Strategy
- Develop and consult on Early Help Partnership plan to translate the strategy into actions for all agencies.
- E-Help system to incorporate work of Family Support Programme and SEND to launch in September 2014.
- Develop governance to strengthen oversight of Early Help
- Re-commission Services for Young People including a range of early help services

What difference for children, young people and families?

- Moving forward we will be able to report on the outcomes framework for the early help strategy.
- MASH and Hubs: performance data suggests reduction in referrals. Contacts being identified as requiring a pathway other than Children's Social Care.

Early Help (including healthy behaviours)

Aim: To identify and address the needs of Surrey's children and families earlier, reducing the need for more intensive, acute or specialist support.

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

HEALTHY BEHAVIOURS

Current position

- Healthy weight pathway for under 5s completed
- Developing healthy weight pathway for 5-19 year olds
- Work ongoing refreshing the obesity needs assessment.
- Sexual Health needs assessment due to be completed by August 2014.
- Work ongoing to define the role of the school nurse in mainstream schools and how they can support the CAMHS school nurse.
- Substance misuse strategy to be consulted on.
- Analysing consultations responses and amending alcohol strategy
- PHSE review complete

Risks and issues for escalation

- School take up of the healthy behaviours related questionnaire.
- Recruitment of school nurses

Next steps

- Develop healthy weight strategy after needs assessment complete – November 2014
- Develop 2015/16 healthy weight for 5-19 year olds commissioning intentions – Autumn 2014
- Commission healthy behaviours related questionnaire – Autumn 2014

What difference for children, young people and families?

- From September 2014 children will know and have better access to a school nurse as every secondary school will have a named school nurse.
- Decrease in number of referrals into treatment (YP aged 18 or under).
- Planned exits (i.e. service users leaving treatment successfully) within Surrey continue to surpass those nationally and this quarter reached 90%.

Complex needs including paediatric therapies

Aim: Improving children's health and wellbeing to give every child the best start in life and ensuring that children and young people with complex needs will have a good, 'joined up' experience of care and support.

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

Current position

- Extensive communications and training plan is in place to prepare for introduction of new system from September 2014.
- New SEND Governance Board met for the first time and will oversee the implementation of the reforms.
- SEND Reform Grant is being used to support capacity to introduce the new system.
- Local Offer 'landing page' launched on SCC website.
- Outcome focussed Joint Commissioning Strategy for paediatric therapies is currently being drafted. This will include a focus on early help i.e. those requiring access to support services but may not need an EHC Plan.
- An outcome focused speech and language therapy assessment workshop took place in July 2014.
- College of Occupational therapists reviewing occupational therapy in Surrey.

Risks and issues for escalation

- Very challenging timescales – Code of practice and regulations only issued in June 2014; implementation September 2014.
- Challenge to introduce a new system while managing old system and transferring people onto new EHC Plans.
- A steep rise (seen nationally as well) in the number of statement requests at this time of the year have put additional workload burdens on teams.
- Predictive data analysis has stalled due a national issue of hospital trusts not sharing some data.
- Access to good early intervention support services (i.e. paediatric therapies) and particularly for under 5s.

Next steps

- Continue use of SEN Reform Grant to support new system whilst maintaining the existing system - Ongoing
- Learning from Personal Budgets Policy – has been out for consultation during September 2014
- Following consultation workshop in September 2014, a fuller timetable for the transfer of statements/LDAs to the new EHCPs will published before the end of September.
- Develop service specification for speech and language therapy – Oct 2014.
- Complete joint commissioning strategy for paediatric therapies – Oct 2014.
- Embed new governance arrangements - ongoing

What difference for children, young people and families?

- Positive feedback from parents who took part in piloting the scheme in Surrey
- A more joined up experience of care for CYP and families – a new SEND Governance Board will be working hard to deliver this.
- We want good parental satisfaction with the SEND system in Surrey and are currently developing a way to best measure this.

Emotional wellbeing and mental health

Aim: Children and young people are supported as close to home and by people they know as much as possible and there are seamless pathways to effective targeted and specialist services where needed.

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

Current position

- Tier 4 beds – Taken the lead to lobby national bodies for more sustainable solution to issue of tier 4 beds.
- SaBP working with acute hospitals, police and out of hours GPs to enhance the knowledge of professionals around the emotional health and well being of young people.
- SCC with CCGs, Policy and SaBP are developing a innovation fund bid for an enhanced pathway service.
- CAMHS Youth Advisors (CYA) have met with NHS England.
- Health and Wellbeing Board endorsed joint emotional wellbeing and mental health commissioning strategy for CYP 2014-17. Three year commissioning action plan drafted to deliver strategy.
- Paper for re-procurement of specialist and targeted CAMHS currently in consultation phase.
- Integrated emotional wellbeing and mental health commissioning group have met.

Risks and issues for escalation

- National commissioning arrangements for tier 4 beds are unlikely to change for 1-2 years.
- YP still being admitted to adult wards as often no adolescent beds available nationally or providers cherry picking. Far more support to access beds being given by Area Team.
- Young People could be left in paediatric beds if no mental health beds available.

Next steps

- Continued lobbying of NHS England and Department of Health for sustainable solution re. access to tier 4 beds for YP in Surrey - Ongoing
- A series of further meetings are planned between YP and NHS England as a “task force” - Ongoing
- CCG and SCC working together to re-procure targeted and specialist CAMHS services. A greater understanding of need and provision will be available - end of September 2014.
- Explore extended outreach service/crisis prevention through innovation fund bid.
- Continued development of the Integrated EWMH commissioning group across all ages for Mental Health, Learning Disability and Substance Misuse - Ongoing

What difference for children, young people and families?

- 34 young people prevented from requiring admission to a child psychiatric unit by HOPE service
- With c.200 schools trained (through TaMHS) to spot signs of mental health, more CYP have access to advice and support earlier.
- Through a renewed joint child and adolescent mental health services (CAMHS) strategy, children and young people will have earlier interventions and organisations will work jointly together around the needs of the child.

Safeguarding including LAC and Domestic Abuse

Aim: To embed and inform specific safeguarding improvements including those directed by the Health and Wellbeing Board, Safeguarding Children Board and the Community Safety Board

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

LOOKED AFTER CHILDREN HEALTH ASSESSMENTS

Current position

- CCG collaborative agreed to provide extra funding to increase capacity for specialist nurses to carry out assessments and provide health support.
- Collaborative working between SCC and G&W CCG project manager to develop service specification for improved service model.
- LAC Health needs assessment completed by Public health.
- Contract variation in place to cover out of county assessments.
- Health outcomes for LAC being developed with the Care Council and a subgroup of the Corporate Parenting Board will be developing an action plan to improve health outcomes.
- Trialling of SLA with a Hampshire for completion of out of county health assessments.

Risks and issues for escalation

- Completion of adoption and fostering assessments for adults. CCGs are aware of this and action is being taken to rectify

Next steps

- Further development of service specification health outcomes and performance measures to assess and understand the health and wellbeing outcomes of LAC – November 2014
- Further discussions with the providers in relation to the service model – Ongoing

What difference for children, young people and families?

- Increased capacity has meant that the most vulnerable children, e.g. those out of county, get timely health assessments
- Health needs assessment in development to get full and complete understanding of the health needs of LAC.
- Children and young people identifying health issues that are most important to them. This is to ensure services and support can continue to address need most effectively.

Safeguarding including LAC and Domestic Abuse

Aim: To embed and inform specific safeguarding improvements including those directed by the Health and Wellbeing Board, Safeguarding Children Board and the Community Safety Board

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Amber	A

DOMESTIC ABUSE

Current position

Domestic Abuse

- Community Safety Board have agreed DA strategy, Health and Wellbeing Board, Children's and Adults Safeguarding have reviewed.
- Domestic Abuse JSNA published and best practice research of DA interventions for CYP and families completed.
- Review of current provision, commissioning arrangements and partner plans for domestic abuse specialist services and healthy relationships preventative work has commenced.
- Initial scoping for specialist services for children and young people affected by domestic abuse commenced
- DA risk assessment checklist adopted by Children's social care workforce.
- DA Multi-agency training offer including e-learning launched.
- OPCC have funded a specialist Children's Worker (16hrs per week) from the 1st October in each of the four Outreach areas.

Risks and issues for escalation

- School take-up of Healthy Relationships Package.
- Commitment by all agencies to agree whole system pathways.
- Commitment by all agencies to whole system commissioning of services, interventions and training.

Next steps

- Business case for domestic abuse specialist services and healthy relationships preventative work to be agreed – September 2014
- Analyse options for DA interventions to be used through the Family Support Programme – Autumn 2014
- Roll-out DA risk assessment checklist to multi-agency early help workforce – August-October 2014 and November/December 2014 for further services
- Quantify need for future training for children's workforce – January 2015
- Finalise commissioning outcomes and spend analysis – September 2014

What difference for children, young people and families?

- Greater understanding of need and provision has led to new commissioning intentions and funding for:
  - A package to inform and advise school aged children about healthy relationships and domestic abuse.
  - Specialist services for CYP and families
- Supporting Families Programme has identified 17% of 252 referrals for intensive support as including a reported victim of domestic abuse – more families will receive support to tackle problems around domestic abuse

Shared understanding of need

Aim: To develop a culture of sharing information on CYP and families so that we can collectively serve their interests in a more joined up way

Key:
Red = Outstanding issues – action required
Amber = Action plan in place to bring on track
Green = On track

Status	Green

Current position

- Work is ongoing to streamline JSNA process for CSF, including updating older JSNA Chapters
- First meeting of multi-agency virtual data group has occurred.
- Surrey Says has been successfully rolled out to CSF.

Next steps

- Develop JSNA Chapters: Families in Need, SEND and Safeguarding CYP – End 2014
- Continue to develop multi-agency virtual data group including producing a high level data gap analysis – Autumn 2014
- Further roll out of Surrey Says across SCC and partners, including training – Autumn 2014

Risks and issues for escalation

- Capacity to ensure actions are completed within desired timescales.

What difference for children, young people and families?

- As a result of a better understanding of need, commissioning priorities have been altered to better match the needs of our communities.
- Children's and parents' views are getting heard and taken into consideration more.

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Surrey Health and Wellbeing Board

Date of meeting	2 October 2014

Item / paper title: **The Surrey Better Care Fund plan**

Purpose of item / paper	The purpose of this item is to formally note Surrey's Better Care Fund (BCF) plan following its submission to NHS England. Surrey's BCF plan **will be presented on the day** following the approval process agreed at the Health and Wellbeing Board on 4 September 2014. **Background** The Better Care Fund is a national programme (announced in the Government's June 2013 Spending Round) which creates a local single pooled budget to support and enable closer working between the NHS and local government. It 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.
Surrey Health and Wellbeing priority(ies) supported by this item / paper	The Surrey Better Care Fund programme for 2015/16 will support delivery of Surrey's Joint Health and Wellbeing Strategy. The focus of the Better Care Fund is providing improved care for older people in community settings. It will therefore have most impact upon delivery of the following Health and Wellbeing Strategy priorities: • Improving older adults' health and wellbeing • Developing a preventative approach • Promoting emotional wellbeing and mental health
Financial implications - confirmation that any financial implications have been included within the paper	The BCF plan will include the financial implications of the schemes to be implemented across Surrey. The BCF is made up of a number of existing elements of funding and covers two financial years. Local areas can choose to add additional funding to their BCF but the minimum required value of the BCF pooled budget for Surrey is: • For 2014/15, the Whole Systems Funding for Surrey = £18.3m. • For 2015/16, the Better Care Funding total for Surrey is a revenue allocation of £65.5m + capital of £6.0m = £71.5m.

	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 (CCGs) 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.
Consultation / public involvement – activity taken or planned	Health and social care providers have been engaged in developing an integrated vision for out of hospital care in each local area for example through the 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. In response to feedback on Surrey's Better Care Fund return in April, Local Joint Commissioning Groups have enhanced their engagement with local providers, particularly those in the acute sector, to develop their local Better Care Fund plans and to ensure the impact of these plans across the system is understood.
Equality and diversity - confirmation that any equality and diversity implications have been included within the paper	Detailed local schemes for the Better Care Fund will continue to be planned through the latter part 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. Equality Impact Assessments have already been undertaken for a number of existing joint schemes which are likely to be rolled forward into 2015/16.
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, 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 Dave Sargeant, Strategic Director, Adult Social Care Tel: 01483 518441 david.sargeant@surreycc.gov.uk
Actions requested / Recommendations	**The Surrey Health and Wellbeing Board is asked to:** • Note the Better Care Fund plan for Surrey; and • Discuss the next steps for Surrey's Better Care Fund planning.

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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.

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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 small area of North West Surrey CCG. Windsor, Ascot and Maidenhead CCG is consequently making a small contribution to the Surrey Better Care Fund but does not form part of the Surrey planning area Note: Windsor, Ascot and Maidenhead CCG will contribute £540,000 to the Surrey Better Care Fund which is to be specifically ring fenced to be spent on Windsor, Ascot and

	Maidenhead CCG patients. This contribution will be put towards re-ablement services to support admission avoidance and timely discharge from acute hospitals. It will also cover any increase in community equipment required to support a more rapid discharge of patients from hospital into the community. • The population of Guildford and Waverley crosses West Sussex in a very small area. Guildford and Waverley CCG is working with the Council and CCGs by contributing to their plans
Date agreed at Health and Well-Being Board:	To be formally ratified in retrospect on 2 October 2014
Date submitted:	**29/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,329,000**
2015/16	**£71,422,000**
Total agreed value of pooled budget: 2014/15	**£3,329,000**
2015/16	**£71,422,000**

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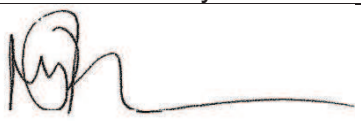
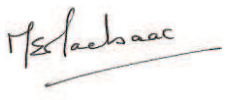
b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS East Surrey CCG
By	 Mark Bounds
Position	Chief Officer
Date	**29/09/2014**

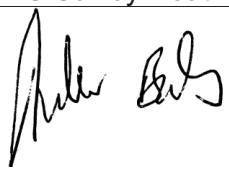
Signed on behalf of the Clinical Commissioning Group	NHS Guildford and Waverley CCG
By	 Dominic Wright
Position	Chief Officer
Date	**29/09/2014**

Signed on behalf of the Clinical Commissioning Group	NHS North East Hampshire and Farnham CCG
By	

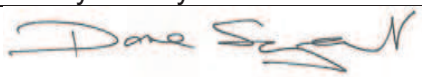
	Maggie MacIsaac
Position	Chief Officer
Date	**29/09/2014**

Signed on behalf of the Clinical Commissioning Group	NHS North West Surrey CCG
By	 Julia Ross
Position	Chief Executive Officer
Date	**29/09/2014**

Signed on behalf of the Clinical Commissioning Group	NHS Surrey Downs CCG
By	 Miles Freeman
Position	Chief Officer
Date	**29/09/2014**

Signed on behalf of the Clinical Commissioning Group	NHS Surrey Heath CCG
By	 Dr Andy Brooks
Position	Clinical Chief Officer
Date	**29/09/2014**

Signed on behalf of the Clinical Commissioning Group	NHS Windsor, Ascot and Maidenhead CCG
By	 Alan Webb
Position	Chief Officer
Date	**29/09/2014**

Signed on behalf of the Council	Surrey County Council
By	 Dave Sargeant
Position	Strategic Director Adult Social Care
Date	**29/09/2014**

Signed on behalf of the Health and Wellbeing Board	Surrey Health and Wellbeing Board

By Chair(s) of Health and Wellbeing Board	 Councillor Michael Gosling  Dr Andy Brooks
Date	**29/09/2014**

c) 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.

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Document or information title	Synopsis and links
Surrey wide	For these documents please go to: www.surreycc.gov.uk 020-8541-7076 kathryn.pyper@surreycc.gov.uk
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 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

Document or information title	Synopsis and links
	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	For these documents please go to: www.eastsurreyccg.nhs.uk 01883-333033 Roger.Hendicott@EastSurreyCCG.nhs.uk
East Surrey CCG Strategic Plan 2014/15-2018/19	Describes the vision of the CCG and blue print 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

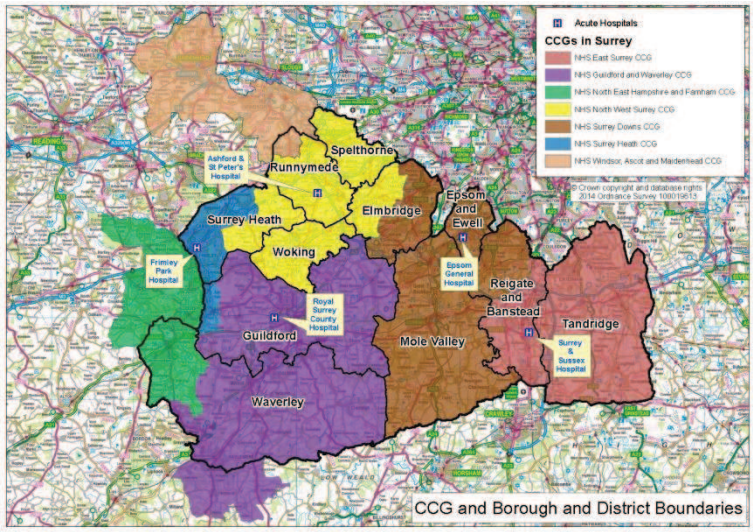
Document or information title	Synopsis and links
	engagement with patient and health service users
East Surrey CCG Patient Engagement and Communication Strategy	Highlights the approach that the CCG takes in engaging and communicating with patients and health service users.
East Surrey CCG Call to Action Report	A report post an engagement event that captures and highlights patient views on health services
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Guildford and Waverley CCG	For these documents please go to: www.guildfordandwaverleyccg.nhs.uk 01483-405450
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 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 and 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	For these documents please go to: www.northeasthampshireandfarnhamccg.nhs.uk 01252 335154
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 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

Document or information title	Synopsis and links
North West Surrey CCG	For these documents please go to: www.nwsurreyccg.nhs.uk 01372 201802
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
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	For these documents please go to: www.surreydownsccg.nhs.uk 01372-201500
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	For these documents please go to: www.surreyheathccg.nhs.uk 01276-707572
Surrey Heath CCG Engagement Timeline	Details the engagement plan with Surrey Heath CCG's stakeholders from February to April 2014 culminating in a system-wide workshop
Surrey Heath CCG Supplementary Submission Information	Describes Surrey Heath CCG's engagement with acute and community providers, Borough and Districts, Health and Wellbeing Board and Public Health and clarifies expected outcomes and investment costs
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

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Surrey is one of, if not the most, complex system in the country. Surrey has 1 County Council, 6 Clinical Commissioning Groups, 5 Acute Trusts, 1 Mental Health Trust, 3 Community Care Providers and 129 GP surgeries (see map below). The next five years will be exceptionally challenging. We face an unprecedented financial environment, radical changes in national policy and the demographic pressures of an ageing population, with a high incidence of dementia. All of this will necessitate a radical strategic shift in the way in we deliver services, a refocus of available resources and integration between health and social care partners.



Despite the complexity of the Surrey system this plan demonstrates how, through integration, we will work together to deliver better outcomes for the residents of Surrey.

The five year vision for Surrey has been developed in partnership with health and social care commissioners, older adults and local stakeholders including our Healthwatch colleagues. Healthwatch Surrey will engage with local system partners, and participate in appropriate governance structures, to ensure that the voices of consumers are heard and are integral to the design and re-engineering of all health and social care services. Working this way will build trust and confidence across and within partner organisations and systems, accelerating progress towards the sustainable services and communities to which we and all partners are committed."

This vision has been outlined in the Surrey Health and Wellbeing Strategy which was developed with the Better Care Fund and older people at the forefront of our thinking. The vision is to achieve the following outcomes:

- Older adults will stay healthier and independent for longer
- Older adults will have a good experience of care and support
- 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.

Surrey Health and Wellbeing Strategy
Older Adult Outcomes

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.

The Joint Strategic Needs Assessment (JSNA) as 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

Our 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"

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.

b) What difference will this make to patient and service user outcomes?

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:

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

It will mean people in Surrey will benefit through:

- 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
- Experiencing health and social care services which are joined up
- Receiving a consistent level of care and support 7-days a week
- Remaining safe
- 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

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

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

- Fully developed out of hospital care, including early intervention, admission avoidance and early hospital discharge through:
  - Engagement with providers
  - Co-design and co-delivery with patients, service users and the public
  - Investment in social care and other local authority services
  - Investment in primary care
  - Investment in community health services
- Effective arrangements for integrated working with shared staff, information, finances and risk management
- 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

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.

For each Local Joint Commissioning Group in Surrey this will mean:

East Surrey

It is envisaged that within 5 years, services currently provided in the East Surrey CCG locality by the community health provider (First Community Health and Care), Local Authority (SCC), and a range of voluntary sector agencies will be working together as one provider team, enhanced through the support of the BCF. There will be a variety of resources targeted to meet the needs of the local communities, specifically to:

- Prevent avoidable hospital admissions and re-admissions through eg early needs assessment, increased access to the reablement and home therapy services, improved risk and falls assessment.
- Improve hospital discharge through, increased access to the reablement service, implementation of the discharge to assess model, streamlining the assessment model to a single assessment, psychiatric liaison in acute and community settings, improved use of health "passports" for people with learning difficulties
- Support people to remain at home
- Provide integrated "In reach" services to acute and community hospitals.

Guildford & Waverley

The most significant change to the pattern and configuration of services is the strategic intention to develop an Integrated Care Organisation (ICO) in Guildford and Waverley. All organisations, whether commissioner or provider share a view that:

- The combined health and care budget for the local population could go further than it does today
- A new model of fully integrated care would enable the delivery of outstanding quality services and step change improvements in productivity and efficiency

The ICO will focus on the population aged over 65 (currently estimated to be 37,000 people in Guildford and Waverley) as this group provide the greatest opportunity to improve quality and reduce costs through integrated care models. It is expected to achieve better care for individuals, better health for the people of Guildford & Waverley, lower costs for taxpayers and commissioners, and greater sustainability for healthcare providers.

Participating organisations will work 'as if they are one' – determining the pathways, the type and location of services based on which will best achieve our aims rather than based on the impact on individual organisations.

Partners are clear that the new models of care will enable individuals to maintain health and independence for as long as possible, result in fewer admissions to hospital and long term residential care, and enable individuals to be discharged from hospital in a more timely manner.

These aspirations drive the desired outcomes:

a. Securing additional years of life for people with treatable mental and physical health conditions
b. Improving quality of life for elderly people and those with one or more long term condition
c. Reducing the amount of time elderly people spend avoidably in hospital

d. Increasing the proportion of older people living independently
e. Reducing the number of permanent admissions of older people to residential/nursing care homes
f. Increasing the number of older people having a positive experience of care, including of end of life care
g. Reducing health inequalities in the local population
h. Reducing overall system costs

A series of principles will underpin the ICO:

- Organisations participating in the integrated care system will work 'as if they are one' – determining the pathways, the type and location of services based on which will best achieve our aims rather than based on the impact on individual organisations
- Service change will be based on the best available evidence and will respond to the views of local people
- As much care as possible will be delivered in a community setting where it makes clinical and economic sense to do so
- Duplication of services should be eliminated wherever possible
- The work to develop future models of care will build on and consolidate work that is already underway in providers, in commissioners and in joint forums across the system

A fully integrated care system will require a new approach to commissioning and contracting with providers, and it is most likely that this will involve longer term contracts and a capitation based payment approach

The ICO will be a partnership of organisations that will take responsibility for the delivery of the end to end 'Frail Elderly Pathway' and a set out outcomes related to that. Primary care is an important player in that partnership and through 'Procare' will have a strong voice around the ICO development table.

A number of workshops have taken place to engage senior health and care professionals, and other key stakeholders (including patient, carer and third sector groups) in the development of the ICO and specifically to design the key characteristics of the service models for each population segment (Active, Adaptive, Assisted, Dependent and Departing).

Successful development and delivery of the new models will require the involvement of key stakeholders from an early stage.

The characteristics of the future model for each segment of the population is summarised through common themes such as:

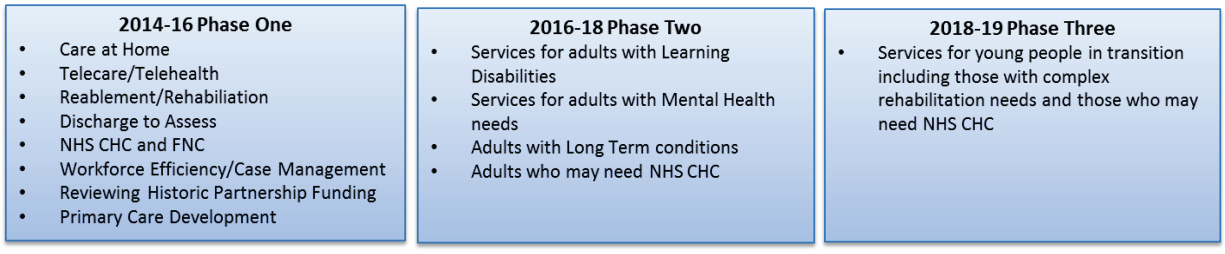
- **People feel in control and empowered**. They have the information they need to make informed choices
- **Focused on the goals of individuals**. The care an individual receives is personalised and focussed on supporting them to achieve their personal goals (not the goals of the system)
- **In depth understanding of the needs of the older population**. The health and care system understands in detail the level of need and risk for individuals and is proactively managing this need
- **Care planning**. Proactive care plans are agreed with those at risk, there is a focus on talking about and planning for the future
- **Care navigators** or key workers are joining up the system for individuals.
- There is a **single point of access** for people into the health and care system. Individuals are not passed around the system.
- **Technology** is being used to provide information and advice tailored to the needs of individuals, and to support independence (e.g. through telemedicine)

The BCF funded work will contribute to the ICO development and meeting the needs of the frail and vulnerable population by developing integrated out of hospital care, including early intervention, admission avoidance and early hospital discharge through:

- Co-design and co-delivery with providers, patients, service users and the public
- Integrated rapid discharge teams, including social workers in the hospital environments
- Development of an integrated frailty pathway
- Establishment of an Integrated hub and spoke Ambulatory Older People Unit
- Integrated community-based multi-disciplinary teams working to stabilise and maintain an individual's normal place of residence
- Delivery of 7-day, 8am – 8pm health and social care services
- Enhanced community based services integrated with primary and social care that are wrapped around practice populations
- Delivery of a telephone based motivational coaching programme for people who are at risk of admission to an acute hospital empowering individuals to take more control of their care
- The development of acute mental health pathways
- Feasibility study to how Rapid Assessment and Intermediate Discharge will impact on the excess acute bed days
- Investment in the voluntary sector to support socially isolated older people to reconnect with their communities and settle at home following discharge
- Delivery of dementia friendly communities that support people to live in their own community
- Introducing effective arrangements for integrated working with shared staff, information, finances and risk management starting with an Integrated Joint Commissioning and Transformation Manager
- Joint accountable leadership through the BCF Joint Commissioners Group to assess risk, plan and co-ordinate care

North East Hampshire & Farnham

Our plan is to approach integration in a phased but interdependent way to avoid destabilising the system of care we are transforming and to simultaneously adopt a "listen, learn and redesign" principle. The following phases have been identified over the next five years across North East Hampshire & Farnham CCG.



Delivering our vision at scale and pace requires substantial change management across each of the health and care systems. To ensure coherence we are establishing an overarching infrastructure and governance framework that runs across all the phases and links to both County Councils as well as our CCG transformation and efficiency plans, ensuring that these changes are integral to the transformation plans of individual organisations within our system. As part of this we are working jointly to deliver the programmes that will translate our strategic vision into operational reality. This will not happen if we do not invest in and support the individual staff working with people using services on a day to day basis. Workforce development is therefore an essential part of our

approach in terms of competency and capability. Specific programmes and funding have been agreed to facilitate the right behaviours.

In phase 1 we will ensure we address three key challenges:

- Avoiding unnecessary cost in the system, moving to lower cost solutions
- Preventing dependency and demand for longer term publically funded services
- Delaying people's dependency on long term health and social care interventions.

Our approach will re-shape and develop the health and social care market and to achieve this we are engaging local health and care providers and local communities to "co-produce" models of care so that:

- **Independence is the expectation** with support at home in the community empowering people to manage their own health and well being
- **Care is co-ordinated** around individuals, targeted to their specific needs, and they will know about and be able to access information, care and support in their local community to keep them at home
- **Responsive, proactive and "joined-up" case management** reduces the likelihood that people will have to rely on more specialist services and rapidly regain their independence when they do
- **Experience of care is positive** with the appropriate services available where and when they are needed
- **Outcomes improve** reducing premature mortality and reducing morbidity

We are currently developing work programmes to deliver the following changes to ensure high quality, sustainable health and care system for all localities across North East Hampshire and Farnham CCG.

- **Our CCG and Social Care Commissioners** will commission and procure jointly
- **Investment** and procurement will support **integrated care delivery**
- **Our Community Providers** will implement new models of service delivery that they have co-produced, drawing on assistive technologies where this is appropriate to do so and connecting with the voluntary sector capacity
- **Our General Practitioners** will be collaborating in wider networks focused on populations of 20 – 50,000 within agreed geographical area to deliver primary care at scale.
- **Investment in Integrated Care Teams** will deliver 7 day working with care co-ordinated around individuals
- **Voluntary and community sector capacity** will be utilised to ensure people are supported to remain independent and able to 'live well', reducing the impact of social isolation
- **Access to high quality emergency care** with services delivered locally where possible, and centrally where necessary
- **The volume of emergency and planned care activity** in hospitals, nursing and residential care homes will be reduced.

Our first priority is to enable transformation of services to align more closely with an individual's potential to maintain and return to independent living. As part of our wider strategic programme to embed integration North East Hampshire and Farnham CCG will be rolling out the following joint transformation work streams:

- **Care at Home** - To deliver a reduction in Care at Home spend through lower overall until prices of care at home packages
- **Telecare/Telehealth** - To deliver recurring savings through the effective implementation of Telehealth by reducing volume of face to face consultations for routine monitoring and through measurable reductions in activity as a result of managing conditions better

- **Reablement/Rehabilitation -** To deliver recurring savings by reducing the risks of intensive cost of care at home, long term residential care or re-admittance through more effective and integrated reablement and rehabilitation provision
- **Discharge to Assess -** To deliver recurring savings by reducing discharge bed days and reducing re-admittance rates through improving the effectiveness of joined up hospital discharge and assessment
- **NHS CHC and FNC -** To deliver a recurring reduction in CHC and FNC spend through more effective market management of contracted spend with current providers and reducing activity through increasing controls over eligibility
- **Workforce Efficiency/Care Management -** To deliver recurring savings by reducing duplication through the development of Integrated Care Teams for out of hospital care and developing joint Health and Social Care commissioning teams
- **Reviewing Historic Partnership Funding (Section 256) -** To deliver a recurring savings through the rationalisation of specific grant funded projects currently funded by S256 arrangements
- **Primary Care Development -** To deliver recurring savings through the implementation of Integrated Care Teams, risk stratification, proactive case management and coordination, information sharing, co-location, single assessment process and strengthened clinical leadership

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These work streams will be underpinned by a number of key enabling elements including:

- Business intelligence
- Estates and facilities
- Technology in care
- IT connectivity
- Legal requirements
- Finance

North West Surrey

NHS North West Surrey CCG Strategic Commissioning Plan sets out our transformation programme for the next 5 years 2014/15 to 2018/19, explaining how we will improve patient outcomes, quality of care, patient experience and value for money.

Working closely with our local stakeholders, local authority partners, our member practices and major providers we have identified six major programmes which will very significantly change the model of care for our local population and ensure that we deliver our ambitious improvements goals, such as:

- We are working in close partnership with Surrey County Council Public Health teams to target specific communities where the health of the population is significantly below our expected levels and deliver programmes to improve.

- We are investing in the delivery of a proactive care model. This model is being designed to support and help people, particularly the frail elderly and their carers, to remain as healthy and independent as possible. Wrapping services around the patient ensuring that they don't reach crisis levels requiring emergency hospital admission. We are developing three Locality Hubs which will be used by integrated multi-disciplinary health and social care teams led by GPs to improve the quality of care we provide in the community. This will include support to provide early diagnosis and intervention for patients with a wide range of potentially serious conditions, to reduce complications and help people to maintain the best possible health. A wide range of community clinics will be provided for a variety of conditions.

- We are redesigning the Urgent Care model to ensure people are quickly directed to the right person and right level of care to meet their needs, reducing the confusion and complexity of our existing model and reducing the attendance level at A&E which is unsustainable at current levels of growth. A mobile multi-disciplinary assessment unit, available to respond within 2 hours and single point of access for professionals (PAPA) ensuring all services are effectively utilised.

- We are ensuring delivery of planned care is focused on providing better value care for our population, using new local community clinics to better support less complex requirements closer to home. For more complex areas we will commission end to end pathways of care to achieve best outcomes for patients and reduce cost. Our aim is to change emergency activity into planned care within acceptable timeframe to the patient.

- We are working to support people with Mental Health conditions or with Learning Disabilities to be better supported with integrated care pathways and regular health checks to ensure we improve their quality and length of life. We will provide better Acute Mental Health service to reduce A&E attendances

We are determined to grasp the opportunity to make the big changes which we think are needed to enable a long term sustainable model of care for our population. We need to shift resources and to embrace integrated opportunities the BCF provides us to better support our ageing population and do a much better job of supporting them to lead independent healthy lives in their own homes for as long as possible. We will embrace and develop the support offered by our local county council and boroughs, social care team and voluntary groups and their commitment to help us achieve this transformation.

To enable us to make these investments in proactive community-based services we will need to make significant reductions in the amount we spend on hospital-based services – we are committed to ensuring that we consult fully with our local population and that we build a consensus for change with a clear understanding of the long term benefits that we believe will deliver our vision of achieving the best possible health for everyone in North West Surrey.

Surrey Downs

Services in the Surrey Downs CCG locality, currently provided by community health providers (CSH), Local Authority (SCC), and voluntary sector (range) will be enhanced and working together as one provider team.

There will be a range of enhanced functions relating to supporting people to remain at home, preventing avoidable hospital admission and improving hospital discharge eg increased access to reablement, improved falls assessment and risk management, implementation of the discharge to assess model, single assessment, psychiatric liaison in acute and community settings, early diagnosis and effective support for people with dementia.

In addition to this there will be Community Medical Teams in Surrey Downs providing significant medical intervention and support to a defined cohort of patients, Primary Care GP's, the integrated teams and in-reaching to acute hospitals.

The BCF governance arrangements in Surrey Downs will oversee and direct transformation progress and the BCF will be utilised as the mechanism to provide whole system funding. As such, without BCF, progress on this agenda would be significantly slower and more limited.

Surrey Heath

The BCF funded work sits within an overall 5 year strategy for health and wellbeing for the community served by the CCG and social care partners. Our strategy uses the framework set by the Surrey Health and Wellbeing Board.

At a local level delivery of our vision will require greater integration between health and social care and this partnership is a theme that runs through our strategic and operational plans. The Surrey Heath system has incorporated the 5 Surrey Health and Wellbeing Priorities into our strategic plan as shared local objectives. The Surrey Health and Wellbeing Board priorities also set the framework for the Better Care Fund and have therefore supported alignment of our strategy and the Better Care Fund Plan where appropriate.

Locally the BCF will directly contribute to:

- A re-shaping of the health and social care spending profile with more resources invested in statutory community services across health and social care, physical and mental health
- Greater investment in the voluntary sector as part of its provider role
- Alignment of commissioning and procurement and sourcing function through a culture of co design and co-production, delivering services through jointly agreed specifications, with agreed joint values incorporating "I statements", agreed joint health and wellbeing outcomes,
- Aligning the JSNA to deliver a joint market position statement with a clear demand and supply analysis.
- More services provided 7 days a week and an improvement in the match between the demand for services and when services are available (supply)
- Increased support and opportunities for our community (social capital) to have a role in supporting people to remain in their own homes for longer
- Opportunities for self-care and our personal responsibility for wellbeing
- A more co-ordinated approach to the prevention of ill health and reduction in inequalities including the recognition of the effect of housing, education, employment and the criminal justice system.
- Improved market management and the stimulation of the range of providers available locally to support people in their own homes
- A more personalised approach to the planning and sourcing of care packages and a requirement for providers to tailor care to the needs of individuals

The Surrey Heath Local joint Commissioning Group has been working together during 13/14 to put many of the foundations for delivery of these changes in place. Sustainability of our local health and social system will require a significant change in the patterns of service usage and a move away from bed based care. This will be achieved through a combination of local knowledge, relationships and programmes supported by Surrey wide BCF initiatives.

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3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Each CCG has undertaken a detailed risk stratification (as outlined in section 7cii) Each stratification document informs local implementation planning and has identified the risk for Surrey.

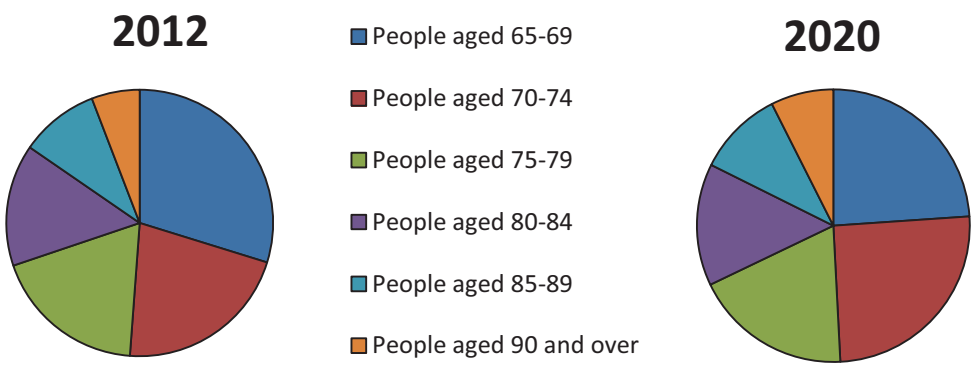
Surrey County Council is an upper tier local authority comprised of eleven lower tier local authorities. Six CCGs sit on the Surrey Health and Wellbeing Board although North East Hampshire and Farnham CCG only has five GP practices within Surrey. The 2011 census

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]

Figure 1: 65+ population distribution in Surrey – a comparison between 2012 and 2020



Source: Projecting Older People Population Information (POPPI – www.poppi.org.uk), as retrieved in July 2013

Figure 2: 65+ population growth estimates for Surrey, 2012 to 2020

	2012	2020	% change
People aged 65-69	60,700	56,900	-6.3%
People aged 70-74	43,600	60,100	37.8%
People aged 75-79	38,000	44,500	17.1%
People aged 80-84	30,100	34,400	14.3%
People aged 85-89	19,500	24,300	24.6%
People aged 90 and over	11,900	17,700	48.7%
Total 65+ population	**203,800**	**237,900**	**16.7%**
Total 85+ population	**31,400**	**42,000**	**33.8%**

Source: www.poppi.org.uk as retrieved in July 2013

The total registered list size of those practices in the five Surrey CCGs and the five 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].

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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

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Each of the Local Joint Commissioning Groups in Surrey has developed local joint Better Care Fund schemes which are included in Annex 1. 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. These local plans form the core of our Surrey Better Care Fund plan.

Surrey wide plans have subsequently been outlined through a hot house process of which the outputs are described in Annex 3. Prior to the hot house process local plans for delivery were developed and are included here for information. Over the next two months work will be taken forward on a local level to join up the local plans and the Surrey wide plans; these newly developed plans will supersede the plan of action described.

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Proposed Surrey-wide umbrella themes as defined by the "hot house process" are listed below. In each CCG system, we have designed local schemes which contribute towards the achievement of our overarching umbrella schemes of (more detail on these schemes can be found in Annex 3):

1) Total Team
2) Whole System Demand Management
3) Mission 90
4) Call for Back-Up

Although more work is required to determine detail at a local level and to share best practice themes and models at a County wide basis, local schemes at CCG level are essential to successful delivery in our complex system.

Total Team	**Whole System Demand Management**
NHS East Surrey CCG: • Enabling People to stay well • Enabling People to stay at home • Enabling Planned Access to services • Enabling People to return home sooner from hospital NHS Guildford and Waverley CCG: • Primary Care Plus • Rapid Response • Telecare • Virtual Wards • Social Care/Reablement/Carers • Mental Health NHS North East Hampshire & Farnham CCG: • Telecare / telehealth • Reablement • Discharge to Assess	NHS East Surrey CCG: • Contractual levers as an enabler to change NHS North East Hampshire & Farnham CCG: • Care at Home • Continuing Health Care / FNC NHS North West Surrey CCG: • Joint whole system demand management NHS Surrey Downs CCG: • Continuing care assessment process NHS Surrey Heath CCG: • Nursing Home and Residential Support

• Workforce efficiency / integrated case management • Primary Care Development NHS North West Surrey CCG: • Integrated Health and social care locality hubs NHS Surrey Downs CCG: • Primary care networks; community medical teams • Continuing care assessment process • An improved and integrated discharge pathway • Rapid response / intermediate care / reablement NHS Surrey Heath CCG: • Admission Avoidance • Early Discharge from hospital • Rehabilitation / reablement	
Mission 90	**Call for Back Up**
• Reviewing historic voluntary sector funding across all CCGs	• County wide scheme under development

Each Local Joint Commissioning Group will have local key milestones associated with the delivery of their local Better Care Fund schemes. Examples from Guildford & Waverley; North East Hampshire & Farnham, North West, Surrey Downs, East Surrey and Surrey Heath are included below:

Guildford & Waverley

Guildford and Waverley are working proactively on reducing the levels of emergency admissions and reducing excess bed days. The following service improvement and initiatives have been prioritised:

- Implementation of our Urgent Care Strategy that incorporates primary care provision within our local Emergency Department
- Review the urgent referral pathway for access to services
- Where services currently exist to provide alternatives to acute urgent care services, it is imperative to maximise the potential benefits
- Better management of patients 65+ helping to achieve reductions in emergency care, including unplanned emergency admissions and A&E attendances.
- Where clinically appropriate admissions do occur, enhanced discharge processes in combination with effective community step down services, can also help to reduce LoS for 65+ acute admissions, thereby reducing both risk and cost while improving patient outcomes and experience.

The overarching strategic intention to develop an Integrated Care Organisation for Guildford and Waverley. It has been established that all organisations, whether commissioner or provider share a view that:

- The combined health and care budget for the local population could go further than it does today
- A new model of fully integrated care would enable the delivery of outstanding quality

services and step change improvements in productivity and efficiency

The ICO will focus on the population aged over 65 (currently estimated to be 37,000 people in Guildford and Waverley) as this group provide the greatest opportunity to improve quality and reduce costs through integrated care models. It is expected to achieve better care for individuals, better health for the people of Guildford & Waverley, lower costs for taxpayers and commissioners, and greater sustainability for healthcare providers.

The following milestones maybe subject to review and amendment:

Milestones	Timescale
Care Model Design and Implementation Groups	November 2014
Implementation Planning	End of November 2014
Care Model Design and Implementation Groups	December – February 2015
Completion of the actuarial assessment	December 14
Establishment of the capita based outcomes contractual framework	Feb 2015

The Better Care Fund is a critical enabler and has enabled the development of a range of partnership initiatives where health and social care providers are working collectively to meet the needs of the frail and vulnerable population who are at risk of emergency admissions and A&E attendances.
The ICO strategic development is the umbrella under which the Better Care Fund Initiatives which have the clear measurable milestones:

Primary care plus+

- Primary Care Frailty initiative mobilised
- Initial monitoring reports will be received in October 14
- Frailty Forum – September 2014

BCF Hospital Improvement Group

- Meeting weekly in various venues (Milford Hospital, GP practices, Haslemere Hospital, Royal Surrey) to address challenges across providers October 2014
- Monitoring data on Virtual ward rounds undertaken in primary care - October 14
- Developing links with the voluntary sector (Age UK) to understand how these services can complement those currently available in the community October 2014

Community Hospital RESET

- Following feedback from the first RESET week, it has been agreed that a community RESET week across the Milford, Haslemere and Farnham sites - late October 14

Acute Hospital RESET

- Plans are beginning to run the second RSCH RESET- November 14

Older Person's Day Assessment Unit

- Direct access to a geriatrician - 'Geriatrician of the day' bleep and contact details to be disseminated across practices in September 2014
- Interface geriatricians to attend primary care Frailty MDTs – piloting attendance at 4 practices in September to further understand the logistics and challenges of frail patients as well as to link in with the Frailty Initiative
- Discussions on the development of a single point of access underway across providers

Virtual wards

- Daily RSCH admissions and A&E attendance data sent to GPs – completed
- EMIS portal – Information sharing agreement being processed with all practices – November 14
- Initial Frailty Initiative monitoring to be received October 2014
- Draft specification under development October 2014
- GP interface proposal October 2014
- Proactive Anticipatory Discharge Planning initiative to be scoped October 14
- Implementation of Proactive Anticipatory Discharge Planning January – March 2015

Rapid response service – fully mobilised

- Performance reports October 14
- Review of pilot initiative, amendments to operating model if required outline November 14
- Implementation of amended operating model December 14

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Mental health

- Organic mental health psychiatric liaison review October 2014
- Redesign of psychiatric liaison service at RSCH December 2014

North East Hampshire and Farnham

Working collaboratively with our local stakeholders, North East Hampshire and Farnham CCG in its five year strategy sets out our transformation programme of work delivered through our six Improvement Programmes to deliver an ambitious and transformational work programme:

1) Empowering Individuals to Take Control of Their Own lives
2) Targeted prevention and earlier intervention for those at risk of becoming unwell
3) Integrated New Models of Health and Social Care
4) Introducing New Models of Urgent and Emergency Care
5) Improving the Quality and Productivity of Planned Care
6) Improving Specialist Care

Under each improvement programme, there are a range of improvement projects in progress that will deliver in 2014/15 as well as a work programme detailing key deliverables over the next five years. Our population will begin to see changes in their health and care services we provide. Examples of these projects include:

- **Prevention and early intervention**
  - Falls prevention and pathway redesign
  - Working with the voluntary sector on carer support, dementia friendly communities, advice and information
  - Developing a healthy HYDRATE programme for residents in residential and nursing homes
  - Health and well-being café for long term conditions
  - Developing a Crisis Café for support people with mental health
  - Improving the rate and quality of Dementia diagnosis
  - Pilot of telehealth project for people with respiratory conditions
- **Responsive primary care**
  - Proposal to develop a community Geriatrician service with outreach of specialist skills from Frimley Park Hospital
  - Care Home In Reach Programmes
- **Proactive integrated care**

- Enhance capacity building with the voluntary sector to scope integration model
- Establish 3 Integrated locality hubs operational by Summer 2015
- Re-commissioning personal care and support
- Collaborative arrangements for Personal Health Budgets and NHS Continuing Healthcare eligibility

- **Appropriate time in hospital**
  - Reviewing bed utilisation across our CCG system to determine future joint commissioning requirements – community, acute and social care beds
  - Review of psychiatric liaison service at Frimley Park Hospital
  - Review and redesign of In Reach matron at Frimley Park Hospital
  - Cost effective planned pathways
  - Embedding "pull model" in hospital discharge teams by ensuring they are embedded within Integrated Care Teams
- **Integrated mental health and learning disability services improvement programmes**
  - Proposal to develop one Single Point of Access across community nursing/mental health services
  - Proposal to expand hydration project to target residential settings that support people with a Learning disability.

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East Surrey

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 and engaging voluntary sector organisations in the delivery of this
   - 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
   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. These teams will work as single multidisciplinary teams with shared workforce plans, shared information sharing platforms and will work collectively to manage the whole of the patient pathway.
- 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
- Making the best use of telecare, telehealth and an AA style service which will enable people to manage their own conditions seeking help as and when is appropriate.
- Increased use of voluntary sector to aid a 10% “shift to the left” in healthcare ie reduce the number of people accessing care at the highest end of the spectrum by bolstering support at the lower end.

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 Planned Access to Services**

- Commissioning care at the right price by increasing accessibility for primary and community care for diagnostics and expert advice from acute providers without paying for inpatient admissions.
- Working with acute providers to increase patient flow and supporting earlier discharge. This would involve closer partnership arrangements between acute hospitals and community bed provision through the use of separate tariffs and subcontracting arrangements

4. **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 building upon best practice developed through systems such as the Sheffield Model.

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: On-going 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

5. **Contractual Levers as an enabler to change**

- Reducing social care nursing fee exceptions
- Reducing Continuing Healthcare fee exceptions
- Community Health PTS savings by jointly procuring PTS services with Health services

North West Surrey

Our Better Care Fund initiatives seek to create an integrated and appropriate out of hospital model over the coming year:

Scheme	Objective	Milestones	Date
Integrated Health and Social Care Model	To ensure there is an integrated and health and social care model which effectively supports the frail and elderly of NW Surrey; proactively supporting	• Engagement and co-design with providers • Co-design and co-delivery with patients, service users and the	By December 2014

	people to be cared for and treated in their community rather than being admitted to the acute hospital	public • Establish 3 Locality Network Boards, chaired by local GP. • Define parameters of investment in social care and other local authority services • Define parameters of investment in primary care • Define parameters of investment in community health services • Review Whole system Partnership Fund spend	
		• Establish three locality hubs to be operational from April 1st 2015 • 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	By April 2015
		• Have effective arrangements for integrated working with shared staff, information, finances and risk management	By July 2015
Integrated Health and Wellbeing Service	To enable the average older person to live one year longer in good health, happier and independently. To develop a commissioning framework with defined outcomes for the over 75 years population. To integrate and streamline a range of voluntary services in order to better prevent admission, facilitate effective discharge, eliminate duplication of functions and improve the patient experience.	• Identify currents spend in voluntary grants in SCC and CCG budgets • Engagement and co-design with providers • Co-design and co-delivery with patients, service users and the public • Market development	By December 2014
		• Publish the commissioning framework with defined	By April 2015

		outcomes for the over 75 years population • Procure services to be delivered through collaboration of the voluntary organisations	
		• New voluntary services commissioning framework go-live	By July 2015
Joint Whole System Management of Demand	To reduce non elective admissions and excess bed days by effectively using health and social care levers. Particular focusing on nursing, residential and home based care.	• Adjust nursing care tender for joint integrated commissioning • Plan incentivisation to residential/nursing homes from excess bed days savings • Agree plan for administrative integration	By Jan 15.

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Surrey Downs

Scheme	Objective	Milestones	Date
Primary Care Networks; Community Medical Teams	To support discharge and prevent admissions and re admissions to the acute sector by providing an enhanced multi-disciplinary medical service across GP practices	Development phase 1/6/14 to 1/11/14	Nov 14
		Network sign up Jan 15	Jan 15
		Go live April 2015	April 15
		Quarterly audit.	Ongoing.
Improving the continuing care assessment process	Ensure improved patient experience and outcomes within the continuing care assessment process	Joint assessment pilot – Phase 1	Q2 14/15
		Joint assessment pilot – Phase 2	Q3 14/15
		Joint assessment pilot – Phase 3/4	Q4 14/15
		Full rollout	From Apr 15
An Improved and Integrated Discharge Pathway.	To enable expedient/timely discharge for patients by ensuring that the full range of multi-agency services are available via a single point of access and streamlined assessment thus reducing length of stay and delayed discharges.	Audits of discharges completed by Dec 14.	Dec 14.
		Development of assessment tools February 15.	Feb 15.
		New pathway agreed by March 15.	March 15
		Go live April 15.	April 15.
Rapid response/Intermediate Care/Reablement.	To ensure there is an integrated and effective step up and step down continuum in order to effectively support people to be cared for and treated in their community rather than being admitted to	Modelling options as part of the integrated teams by January 15.	Jan 15.
		Development of protocols re access and admission criteria and patient acuity by	April 15.

	the acute hospital.	April 15.	
		Review and rationalise bed base and configuration May 15	May 15.
		Implement model during 2015.	1/4/15-31/3/16
Integrated Services	To integrate and streamline a range of services in order to better prevent admission, facilitate effective discharge, eliminate duplication of functions and improve the patient experience.	Develop service model for integration by November 14.	Nov 14.
		Develop business case by Dec 14.	Dec 14.
		Consultation Dec 14/Jan 15	Jan 15.
		Final modelling Feb 15/March 15. Go live April 2015.	April 15.

9

Surrey Health

A stepped approach to implementation is detailed below. Learning from local evaluation and best practices will inform each stage. Provider feedback will be key.


Q4 13/14
• Define future states "end states" - co-design workshop.
• Begin to collate information on best practice and collate information of currrent services from existing sources. Increased shared understanding.
Q1 14/15
• Co-design workshop to describe existing services, systems and processes from a number of perspectives & key areas for change against future state
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 1st April 2015. Implement transition plan
• Communicate proposed changes to local population & all key stakeholders
Q1 15/16
• Fully implement pooled budgets and assoicated services
• Review outcomes and adjust
Q2 15/16
• Identify planned changes for 16/17
Q3 15/16
• Develop transition plan and contract strategy to deliver required changes from April 2016
Q4 15/16
• Agree implementation process with providers and put enables in place to "go live" from 1st April 2016. Implement transition plan
• Communicate proposed changes to local population & all key stakeholders

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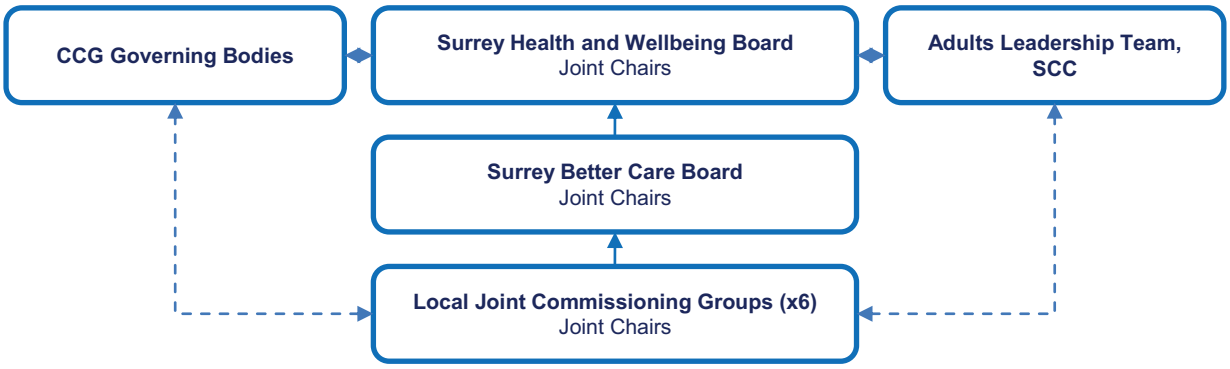
b) Please articulate the overarching governance arrangements for integrated care locally

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 (risk sharing agreement yet to be agreed as described in section 7).
- The Local Joint Commissioning Groups will be responsible for signing off the locally developed implementation plans and their related impact assessments by November 2014.
- 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 are using 2014-15 to trial this model as we 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.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Local Joint Commissioning Groups (LJCGs) are responsible for the investment decisions and for the management and oversight of delivery of the schemes set out in their local joint work programme. Progress against local plans is reported to the Surrey Better Care Board on a quarterly basis and this is then reported collectively to the Surrey Health and Wellbeing Board. The LJCG quarterly report is made up of four elements – activity milestones; provider engagement milestones; performance against the BCF and local metrics; and finance spend. As part of this quarterly reporting process, LJCG are asked to outline their mitigation actions should any aspect of their plan go off track.

In specific LJCGs the following local arrangements are in place:

East Surrey

The LJCG has representation from key project leads that are responsible for escalating risks and these risks are managed by the LJCG on an ongoing basis. This is supported by a Project Management Office which oversees the risk management of all BCF related projects.

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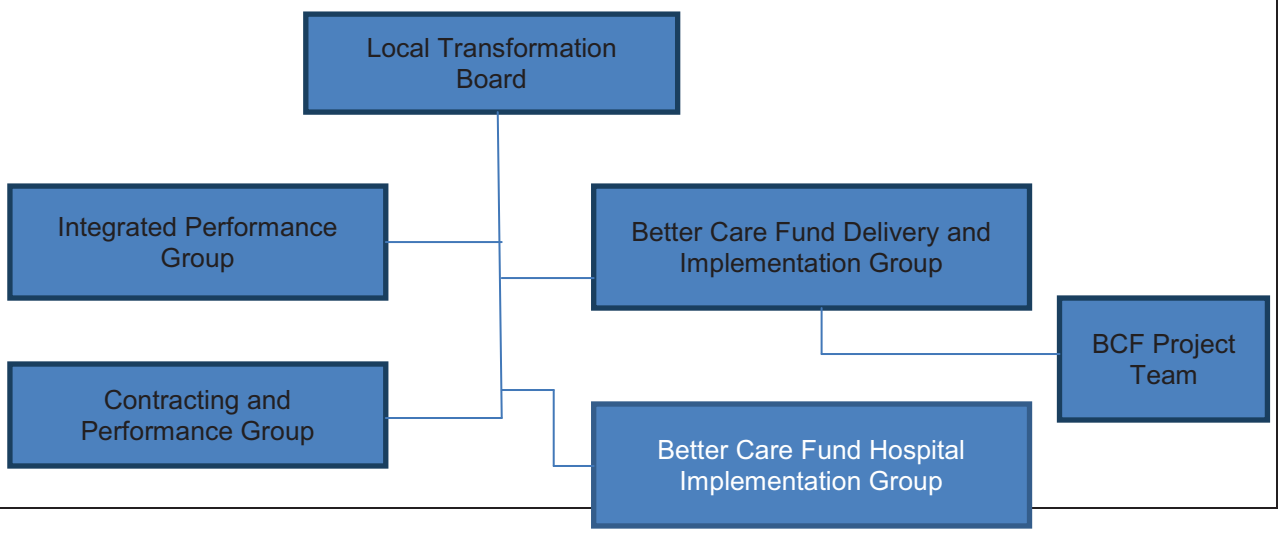
Guildford & Waverley

The Terms of Reference for the BCF Local Joint Commissioning Group is attached. At a local level in Guildford and Waverley, additional groups have been set up with a specific purpose.

- The BCF Hospital and Implementation Group is a weekly meeting held at the acute trust. It has a focus on managing the delivery of schemes that will rapidly discharge patients from hospital and reduce excess bed days.
- The BCF Delivery and Implementation Group focuses on managing schemes to build primary and community care to support admission avoidance and A&E attendances.
- The BCF Project Team focuses on the delivery of integrated projects such as the 'hub and spoke' frailty unit. It reports into the BCF Delivery and Implementation Group.
- The Systems Resilience Group focuses on schemes to reduce A&E attendances. The membership of all groups is composed of representatives from partner organisations.

The Governance Structure for these two groups is set out below:



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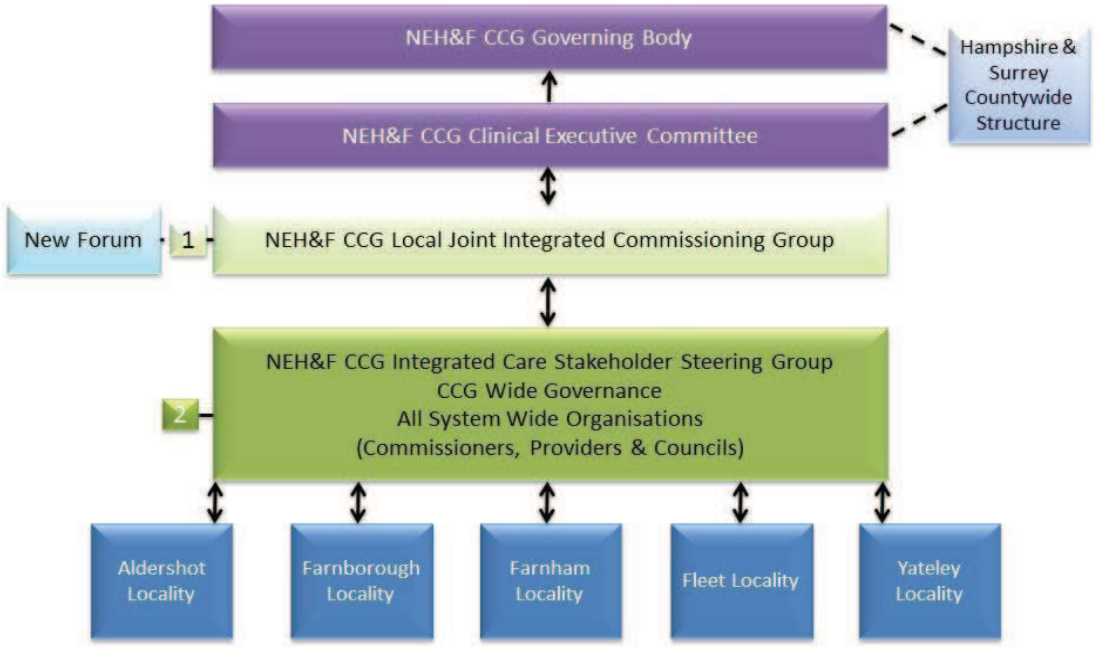
North East Hampshire and Farnham

North East Hampshire and Farnham Clinical Commissioning Group have developed robust local governance arrangements for the management of the Better Care Fund.



The work of the Local Joint Commissioning Group (LJCG) (1) is supported and directed by the Stakeholder Steering Group.

North West Surrey

The management of all Better Care Fund related schemes are managed through a variety of forums within North West Surrey CCG and supported by the governance structure for system wide assurance.

Each programme of work and its associated projects, are managed through a Strategic Change Board and Clinical Reference Group and are subject to its terms of reference, project initiation documentation, change management and remedial action plans, and supported by internal escalation through Risk Committee to Clinical Executive, the Governing Body, and North West Surrey Transformational Board.

Surrey Downs

There is a County wide Better Care Fund Board that oversees each areas plan and utilises the opportunity to share best practice and innovation across the six CCG's.

The Surrey Health and Wellbeing Board have an overarching scrutiny responsibility for the Surrey wide BCF plan. This provides local, political engagement to the process.

The Surrey Downs CCG has a Transformation Board with membership from local key stakeholders and providers and regularly receives reports on BCF progress.

The Surrey Downs Health economy also has a Local Joint Commissioning Group co-chaired by the Chief Officer (CCG) and the Assistant Director of Adult Social Care (SCC) which jointly governs, monitors and makes local decisions regarding the Surrey Downs CCG BCF plan. All local remedial action is instigated via the Local Joint Commissioning Group and there are lead accountable officers for all projects and work streams.

Surrey Heath

The Local Joint Implementation Group (LJIG) has delegated management and oversight of the delivery of the BCF plan and will be the forum for joint decision making on any remedial actions. It is the forum through which joint accountability will be exercised.

Membership is at Director level and the individual members will have the authority to both make strategic decisions on behalf of their organisations, if in line with agreed organisational strategic plans, and to deal with all operational issues unless the delegated responsibilities to the individuals would require escalation to the CCG Governing Body or Adult Leadership Team.

There are no intermediate decision making committees or groups between the LJIG and the CCG Governing Body or Adult Leadership Team.

Local joint deliver structures are in the process of being strengthened with:

- The appointment of a dedicated adult social care assistant director for Surrey Heath to provide delivery leadership
- Inclusion of Borough Council membership on the LJCG
- The appointment of a joint commissioning manager with project management BCF delivery responsibilities
- The establishment of Surrey Heath delivery group with both commissioner and provider representation across a wide range of statutory and non-statutory providers including the police.

9

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

East Surrey

Ref no.	Scheme
1	We have an overarching programme called ***Care Pathway Transformation*** which will deliver the BCF programme within East Surrey. The programme has been developed by engaging with wider Surrey through a hot house process and then localising these outputs to build upon existing work as well as progress new areas of focus. Collectively the entire programme delivers the benefits; these are described as one scheme with 5 aspects to the programme – the detail of which is provided below.

1	***Enabling People to stay well***
1a	Admission avoidance through a multidisciplinary team approach with primary and community health and social care
1b	Universal Benefit Service
1c	Mental Health Community Connections
1d	Personal Health Budget Implementation
2	***Enabling people to stay at home***
2a	Telecare
2b	Telehealth including AA Project
2c	Reablement Staffing, community Equipment and Occupational Therapy (all to be reviewed as part of our ongoing development of plans and to be included within our multidisciplinary team approach)
2e	Mental Health - Dementia
2g	Mental Health SDS
2h	End of Life
2i	District & Borough
2j	Mission 90 – increased use of voluntary sector to reduce activity by 10% across the spectrum of care from the most acutely ill to those that can manage care at home
3	***Enabling Planned Access to Services***
3a	Commissioning Care at the right price
3b	Early Supported Discharge
3c	Carers Breaks
4	***Enabling People to return home sooner from hospital***
4a	Hospital Staffing
4b	Red Cross
4c	Stroke Support
4d	Development of Integrated Night Response Service
4e	Therapy Intervention
4f	Sourcing Staffing
5	***Contractual Levers as an enabler to change***
5a	Reduce social care nursing fee exceptions
5b	Reduce CHC fee exceptions
5c	Community Health PTS Savings

Guildford & Waverley

Ref no.	Scheme
1	Primary Care Plus+
2	Rapid Response
3	Telecare
4	Virtual Wards
5	Social Care / Reablement / Carers
6	Mental Health

North East Hampshire and Farnham

Ref no.	Scheme
1	Care at Home
2	Telecare / telehealth
3	Reablement and rehabilitation
4	Discharge to assess
5	Reviewing Historic Partnership Funding
6	Integrated Provider Delivery Model
7	Primary Care Development

North West Surrey

Ref no.	Scheme
1	Integrated Health and Social Care “Locality Hubs
2	Integrated Health and Wellbeing Services – “Mission 90”
2a	Integrated Health and Wellbeing Services – “Call for Back-up”
3	Joint Whole System Management of Demand

Surrey Downs

Ref no.	Scheme
1/45	Primary Care Networks/ Community Medical Teams
2/46	Improved the Continuing Care Assessment Process
3/47	Improved and Integrated Discharge Pathway
4/48	Rapid Response/ Intermediate Care/ Reablement
5/49	Integrated Services

Surrey Heath

Ref no.	Scheme
1	Admission avoidance
2	Early return home from hospital
3	Nursing/residential homes
4	Rehabilitation/reablement

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
1. Failure to accurately assess the financial impact of the introduction of the Care Bill in 2016	5	5	25	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, in particular voluntary sector (Total Team, Mission 90)	5	5	25	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	5	5	25	Transition planning and co-design critical. Close project management and pre-planned decommissioning schedules to underpin plan
4. Inability to model impact of programmes accurately to secure system wide sign up to increases/ decreases in activity	5	5	25	Involve providers in modelling and programme delivery to increase likelihood of commitment to schemes
5. Impact analysis of implementing different models on the whole workforce at different timeframes which could have detrimental impact on all providers (Total Team)	5	5	25	Baseline review of current services to be undertaken. Align workforce changes across health and social care with one overarching development strategy
6. Effective communication needed in order to ensure stable staffing levels and sufficient	5	5	25	Develop and implement health and social care communication strategy

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
productivity (Total Team)				
7. Financial efficiencies may be difficult to extract from the system (Total Team)	5	5	25	Set indicative resource and financial envelope both across Surrey and locally. Robust financial governance to be reviewed and managed via the Better Care Board
8. Securing contractual agreement to reduce activity and financial value, including 6 month procurement notice of review (Mission 90)	5	5	25	Clear communication to providers via Commissioning Intentions and tender adjustments where required
9. Insufficient resource is released from the acute sector: • The phasing of the activity is not released in line with re-investment plans • The activity volumes released have a lower tariff than the £1,490 defined in the BCF guidance. • Payment by Results arrangements may distort the anticipated reduction of acute spend via emergency threshold arrangements • Overall quantum may not match anticipated contribution.	5	5	25	• Operation of the payment for performance mechanism will mitigate some of the NHS risk. • Reinvest plans will need to be scaled to agreed planned reductions in activity and phased in line with the release of resources; • NHS in-year contract performance will monitor the financial impact of reductions in emergency activity; • NHS contribution to the care act may be aligned to the reduction in emergency activity • A contingency fund will be held by the NHS to mitigate differences between the planned and actual reduction in emergency admissions.
10. Delivery plans for agreed programmes of integrated working are insufficiently rigorous and robust to provide confidence in delivery to scale and time	5	5	25	Apply a rigorous monthly budget monitoring process to ensure that both any potential overspends on projects are identified so action can be taken to rectify the position and any potential underspends are flagged so partners can agree how this funding should be re-invested

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
11. Insufficient resources are released to protect existing social care services	3	5	15	• Apply a rigorous project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved • Report regularly to both the relevant Local Joint Commissioning Groups and the Better Care Board, so that both local and countywide trends, and any potential problems, can be picked up and dealt with expediently.
12. Agencies are unable to change relationships, culture and behaviours	3	3	9	Strong leadership from the Surrey Better Care Board. Programme of change management interventions to support service transformation
13. Availability and capacity of the provider workforce to deliver the new model of care e.g. Community and Social Care, independent and voluntary sector workforce (staff numbers, competencies/skills, money).	3	3	9	Provider workforce capacity and contract plans will be an integral part of the planning process before a decision to implement.
14. Costs of the new system in health and social care exceeds return	3	3	9	Robust financial management arrangements are put in place
15. Improvement is not demonstrated against national and local metrics and performance element of the Better Care Fund is not secured	3	3	9	Ensure sufficient capacity and robust arrangements to monitor and report against national and local metrics as part of the governance arrangements
16. Insufficient engagement with patients, service users and the public, so future services do not	3	3	9	Ensure sufficient capacity and expertise is made available to deliver a comprehensive communication and

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
meet the needs of the local community				engagement plan
17. Insufficient leadership and/or operational capacity to deliver this major transformation change programme	3	3	9	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
18. Lack of improvement in the continuing healthcare process as part of the overall discharge pathway	3	3	9	Implement the programme of change arising from the recent review of continuing healthcare
19. Level and pace of discharge from hospital does not increase as required	3	3	9	Establish an integrated discharge network/model across services
20. Complex changes may bring about risks in service continuity that need to be managed carefully particularly for those with long term conditions, dementia etc	3	3	9	Ensure best whole systems approach to care
21. Sharing of patient information between providers due to insufficient IT systems will impact deliverability of project outcomes	3	3	9	Providers to sign joint agreement for sharing free flow of information and patient data through secured network
22. Unplanned activity – Emergency Department attendance and non-elective admissions - do not reduce at the level or pace required	3	3	9	Analyse required changes, joint planning and management of acute sector bed capacity reduction
23. Care Bill implications result in a reduced engagement by independent sector providers to develop an affordable social care infrastructure	3	3	9	Promote good engagement with market as strategic partners to support sustainability, focus on asset base of local communities to deliver most cost effective models of care.
24. Dependency on Primary Care buy-in to developing new model	3	3	9	Clear communications and direct engagement from the LJCGs with local GPs and

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
(Total Team)				primary care teams to be part of the strategy
25. Public perception of an apparent decrease in service (e.g. reablement 2 week criteria) (Total Team)	3	3	9	Ensure sufficient capacity and expertise is made available to deliver a comprehensive communication and engagement plan
26. Expected outcomes not achieved (Mission 90)	3	3	9	Robust third sector joint commissioning, moving away from funding via grant schemes to delivery of specific outcomes
27. "Call for Back-up" scheme - There is a potential challenge that this could be perceived to contravene the NHS core principle of "Free healthcare at the point of delivery"	3	3	9	Clarity of governance and purpose of potential seed funding by the Better Care Board.
28. Realignment of health and social care, redesigned local structures leads to a confusion within the population and district and boroughs.	2	2	4	A strong joint leadership model with joint communications will mitigate risk
29. "Call for Back-up" provider able and willing to interface with whole system	2	2	4	Market scoping / engagement to have clear specifications
30. "Call for Back-up" user affordability	2	2	4	Pilot engagement which indicated public support to be reviewed.
31. "Call for Back-up" potential provider market	2	2	4	Market scoping / engagement to be undertaken including contacts to be made with other Counties where similar schemes are already in use.
32. Market engagement with the updated principles (Whole System Demand Management)	2	2	4	Review nursing care tender and commissioning intentions for joint integrated commissioning
33. Increased admissions direct to nursing homes (Whole System Demand Management)	2	2	4	Ensure best whole systems approach to care and monitor via Better Care Board
34. Insufficient Extra Care	2	2	4	Programme of change

There is a risk that:	How likely is the risk to materialise	Potential impact	Overall risk factor	Mitigating Actions
to support the model (Whole System Demand Management)				management interventions to support service transformation

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

An assessment of the specific system risks has been undertaken, including growth assumptions and individual pathway redesign.

The County Council and the six Clinical Commissioning Groups in Surrey have agreed to put together contingency plans and risk sharing arrangements, in line with the development of detailed implementation plans by the end of November 2014, based on the refinement of plans.

The plans described will be dependent upon collectively agreeing the risk sharing agreement.

9

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Care and support initiatives being implemented Surrey-wide by Surrey County Council and partners, and which align with the schemes set out in the local joint work programmes include:

- Surrey's Older Adults Health and Wellbeing Action Plan 2014-2016 and Surrey's Living and Ageing Well Agenda for Older People. These have been co-designed and will be co-delivered by health and social care partners, to ensure:
  - Older adults stay healthier and independent for longer
  - Older adults with dementia have access to care and support
  - Older adults experience hospital admission only when they need to access urgent care services and will be supported to return home as soon as possible
  - Older carers are supported to live a fulfilling life outside caring

- Family, Friends and Community Support which is a change programme being prioritised by Adult Social Care. Family, Friends and Community Support is designed to improve individual and community resilience through connecting families to the support and other resources available in their community, and looking at them as 'assets' i.e. with something to contribute to their community, rather than just someone in need. This change programme will look at how strategically the County Council develops the capacity to support its demography and targets its workforce planning and education, asset mapping, transport, advice and information services.

- Surrey's Health and Social Care Integration programme, of which the Better Care Fund is one part, takes a whole systems approach. Whilst the Better Care Fund is driving forward integration across Surrey's health and social care system, it is being supported by four

'enabler' projects - Equipment & Adaptations; Data & Information; Leadership & Effective Team; and Workforce Development.

- The review of all local grants and contracts within health and social care with the aim of aligning objectives and outcomes to Better Care Fund objectives. A formal joint review is taking place to meet individually and discuss aims and objectives with wider providers care and support providers during August 2014.

East Surrey

The Local Joint Commissioning Group (LJCG) for East Surrey will form the co-ordinating point for bringing together the care and support initiatives and service redesign projects. Plans will be shared, agreed and joint actions embedded through the LJCG process and governance. A Gap Analysis will be conducted by or through this group and the business case for whole system redesign will be presented for sign off.

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The integration agenda will need to consider how reablement and social work may be integrated with community health teams and how the work of the local district and borough councils and voluntary sector providers can contribute to this agenda within the East Surrey Locality.

The Prevention, Personalisation and Partnership initiatives (PPP) with Districts and Boroughs have provided scope for the development of local preventative support that aims to support the development of services to support Friends Family and Community.

Guildford & Waverley

- The Better Care Fund Hospital Implementation Group is a weekly meeting with representatives from the CCG and across all providers (acute, community, social services, mental health, continuing healthcare, and care/nursing homes) with the purpose of improving patient flow through the hospital and discharging patients in a timely manner to the most appropriate place of care.

- The Better Care Fund Delivery and Implementation group is a 3-weekly cross-provider meeting with the aim of addressing issues and implementing new ways of working to avoid unnecessary unplanned admissions. Schemes include enhancing community support services to deliver services seven days a week 8am-8pm working as part of multi-disciplinary teams across acute, primary and social care with a focus on patients over 65 years old. This group also has oversight of the delivery of the ambulatory older people unit which follows a 'hub and spoke' model between acute and community services. The hub will incorporate an acute outpatient clinics and a 'hot day hospital' for the frail and elderly patient population of Guildford and Waverley and will complement the community spokes that will offer therapy, reviews and follow up appointments.

The objectives of the project are:

- To provide a single point of access to frail and elderly services
- To provide rapid assessment, diagnostic and treatment services to the elderly/frail population including therapy
- To be a service with integrated teams modeled to fit around patient needs that is simple and easy to navigate
- To reduce unnecessary use of acute trust beds and inpatient admission and readmissions
- To support the 'choose to admit' and 'discharge to assess' sections of the GW Frailty pathway
- To support patients in maintaining independence and returning to home, where

appropriate
- To provide a seamless pathway of services and care to patients
- To provide frailty expertise to the proactive care and active case management

Other initiatives related to care and support that these plans align with are:
- Integrated Care Organisation development
- Prevention work being undertaken by Borough Councils and Public Health
- Care worker recruitment
- Care home work
- Personal health budgets
- Telehealth, telecare, and totally health behavioural motivational coaching
- Disabled Facilities Grants by Borough Councils
- Red Cross initiatives to support discharges
- Integration of Community end of life and hospice provision supporting people to die in their place of choice
- End of Life strategy to develop an end of life care pathway
- Dementia Strategy to review the existing service model
- Primary care and community support services development – enhanced services with seven day working

North East Hampshire and Farnham

A number of projects that constitute the wider out of hospital care model have been designed and agreed, with providers incentivised to deliver the specified outcomes through CQUIN, DES and other schemes. The list below provides a summary of these wider projects that together create the building blocks for integration:
- Care at Home
- Telecare/Telehealth
- Reablement/Rehabilitation
- Discharge to Assess
- NHS CHC and FNC
- Workforce Efficiency/Care Management
- Reviewing Historic Partnership Funding (Section 256)
- Primary Care Development

We are also collaborating with the voluntary sector to design and deliver our future integrated services.

North West Surrey

North West Surrey CCG recognises that in the short-term, given the pressure on its acute hospital, initiatives that enable the care system to manage crisis will have to be prioritised. So early stage initiatives and investment have all been focussed on rapid development of primary care, 7 day working, and increasing non-acute provision of reablement and rehabilitation for specific cohorts – those who have fractures following falls, those who have experienced a stroke, and those who are frail.

In order to address the specific issues of reducing non-elective admissions during the last two quarters of 2014-15, the following initiatives are in process:
- Improved capacity modelling, system flows and scenario planning – workshops September; actions resulting completed by December 2014
- Development of NHS 111 – behavioural campaign July-Sept 2014; Winter Campaign Oct

2014-March 2015 aligned to DoH national campaign

- Additional capacity for primary care – weekend GP cover Woking and Weybridge; extended cover including evenings/Mondays to run October 2014-June 2015
- Priority visit initiative with specific GP practices, encouraging early visits and use of rapid response throughout winter period to achieve reduction acute hospital admissions
- Improvements in primary care input to care homes throughout quarters 3 & 4
- Working Age Adult Liaison Psychiatry weekend and twilight service; Older Age Psychiatry joint working with Care of the Elderly teams at Woking and Weybridge Community Hospitals Nov 2014-March 2015
- Seven Day working arrangements 12 months Sept 2014-August 2015 – GP mini-ward rounds Walton and Weybridge Community Hospitals at weekends to enable 7 day discharge
- Weekend and bank holiday X-ray provision 9-4.30 at Woking and Weybridge Walk-in Centres
- Increase in rapid response in-reach cover to ASPH 6pm – 8pm weekdays and 8am -4pm weekends to return those who attend to home
- Pump-priming of highest priority elements of ASPH 7-day working strategy – increasing medical cover evenings and weekends, additional dietetics, Speech & Language Therapies, pharmacy, radiography and therapy weekends.
- Targeted work to reduce frequent A & E attendance for alcohol related problems
- Medicines optimisation in care homes
- Improved social care cover to expedite acute discharge and prevent admission
- Pulmonary rehab pathway development

Surrey Downs

The Local Joint Commissioning Group for Surrey Downs is the major vehicle for bringing together the care and support initiatives and the CCG service redesign projects. All plans are shared and joint actions are embedded via this process. 'Gapping and mapping' exercises have been conducted by this group across all agencies and the business case for whole system redesign has been presented and signed off.

The major system change being managed is the integration of care services such as Reablement and Social Work with the community health teams. In addition to this there is a hub and spoke arrangement for a range of voluntary sector care and support provision which also brings together the work of the three Borough Councils within the Surrey Downs locality.

The Prevention, Personalisation and Partnership initiatives (PPP) with Districts and Boroughs have provided scope for the development of local preventative support that aims to support the development of services to support Friends Family and Community.

Surrey Heath

The list below provides a summary wider schemes that will underpin the Surrey Heath approach to integration

- Integrated Care Teams
    - Joint Assessment
    - Admission avoidance
    - Data information sharing
    - Risk stratification
    - Integrated workforce planning

- Residential and Nursing Care Home Support
- Integrated Virtual Wards and Risk Stratification
- A review of technology and equipment provision

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Surrey County Council

Surrey's Better Care Fund plan aligns with the Surrey County Council's Adult Social Care 5 year strategy, where the ambition is to:

- Connect individuals with family, friends and community support networks so they can live independently and prevent or postpone the need for funded care and support services
- Work collaboratively with health and other partners to deliver integrated community health and primary care services to improve the health and social care for people
- Provide leadership in the joint commissioning of health and social care services to ensure diversity, quality, cost effective and sustainable services
- Offer universal advice and information services to all local people to promote their independence and wellbeing
- Continue our commitment to personalisation, with all systems, processes, staff and services giving people choice and control over their lives

East Surrey CCG

The East Surrey CCG Vision and Strategy was developed alongside the Health and Well Being Board Strategy and is completed aligned. BCF plans are an integral part of the delivery of the East Surrey two year operation plan and five year strategy and are highlighted as such within the relevant documentation. The key focus is on developing an approach to delivering out of hospital care, focusing on prevention and early diagnosis and improved efficiency and productivity within the health and social care sector. GP Practices were involved in shaping the East Surrey CCG five year strategy and receive regular updates on projects being undertaken.

Guildford & Waverley CCG

NHS GW CCG transformation programmes are presented in terms of the six characteristics of a high quality, sustainable system that will enable delivery of the seven outcome ambitions:

- Ensuring citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider Primary Care, Provided at Scale
- A Modern Model of Integrated Care
- Access to the Highest Quality Urgent and Emergency Care
- A Step-Change in the Productivity of Elective Care
- Specialised Services Concentrated in Centres of Excellence

The NHS GW CCG Operating Plan lists out our commissioning intentions for 2014/15 which align with the BCF plans:

- Eliminating excess bed days through enhanced discharge from community services
- Improve Community Nursing productivity and integration with Primary Care

- Enhanced urgent care provision to reduce Accident and Emergency attendances
- Out of Hours (OOH) procurement aimed at integrating OOH with our agreed clinical pathways, avoiding missed opportunities for quality and efficiency
- Implement Referral Support Service to allow for on-going real-time service mapping, and optimisation of clinical pathway
- Verify consultant to consultant (C2C) referrals are appropriate and eliminate those without benefit
- Reduce tariff for telephone follow ups (encouraging telephone not face-to-face follow up)
- Move specialties to community provision such as dermatology and ophthalmology
- Targeted stop smoking interventions to specific populations
- Implement structured education and support to clinicians, for long term conditions such as diabetes
- Improve self-care programmes for conditions such as chronic obstructive pulmonary disease (COPD) and depression
- Improve access through Improving Access to Psychological Therapies (IAPT) to increase coverage to 15% by April 2015
- Redesign rehabilitation services across mental health and learning disability services to ensure care and support is provided in people communities

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The Operational Plan sets out how NHS GW CCG:

- Plans to deliver local outcomes for the people of Guildford and Waverley to improve health
- Meets its responsibilities under the NHS Constitution
- Achieve the right levels of activity to delivery healthcare for local people, and
- Uses the 'Better Care Fund' to transform local service delivery

North East Hampshire & Farnham CCG

To enable delivery of the North East Hampshire & Farnham CCG 5 year Strategy, 2 year Operational Plan and Better Care Fund we are:

- Commissioning jointly with Surrey County Council, using the Better Care Fund to transform services
- Redesigning payment and contractual mechanisms
- Improving how we work together to improve services
- Improving information systems to improve care

North East Hampshire & Farnham CCG 5 year Strategy aligns with the Better Care Fund, which is designed to:

- Be one element and lever of the development of integrated services.
- Provide an opportunity to focus attention on those areas where we need or want to integrate services as a first step. This is focussed on those areas where there is most overlap between health and social care for adults and in particular Older People.

Key areas include:

- Continuing Health Care (overlap being around both the assessment and review process as well as the purchasing of care or arrangement of personal budgets)
- Reablement (usually occurring after a spell in hospital or a crisis at home to help avoid a hospital admission)
- Care co-ordination (individuals with complex needs who use both health and social care services, importantly this usually interfaces with primary care too)
- Extending joint commissioning with Surrey County Council

- Create a shared plan for the totality of health and social care activity and expenditure.
- Work with Borough Councils to improve health outcomes at the district level Health and Wellbeing Boards that bring together commissioners and providers to help co-ordinate activities to deliver shared outcomes at a very local level.

North East Hampshire & Farnham CCG 2 Year Operational Plan aligns with the Better Care Fund, which is designed to:

- Reduce the number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- Increase the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services
- Reduce delayed transfers of care from hospital
- Reduce avoidable emergency admissions
- Improve Patient / service user experience
- Increase the diagnosis rate for people with dementia
- Increase the number of older people (aged 65 and over) receiving reablement services

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North West Surrey CCG

In designing the 5 year strategic commissioning and 2 year operating plans, North West Surrey CCG consciously ensured the vision and aims align with Better Care Fund objectives. Each of the programmes identifies this in the programme briefs and has formed a central part of the communicated message to and with partners. Since the publication of our 5 year strategic commissioning and 2 year operating plans, our programmes of work have evolved and consolidated, notably the integrated care plan and locality hub development, which have strengthened the alignment with Better Care Fund plan of action.

Surrey Downs CCG

The Better Care Fund plan aligns fully with the Surrey Downs CCG five year strategic commissioning plan and all Adult Social Care strategies. The work streams within the BCF programme are significant projects integrated into all other operating and commissioning plans and as stated form a significant part of the oversight responsibilities of the Transformation and SRG Boards.

The individual BCF schemes fit under the umbrella headings within the overarching five year Integrated Commissioning Plan of Surrey Downs CCG.

Surrey Heath CCG

The 5 year strategic vision for the Surrey Heath health economy fits within the framework set by the Surrey Health and Wellbeing Board. Delivery of this vision through our 2 year operating plan will require greater integration between health and social care and this partnership is a theme that runs through our strategic and operational plans. The Surrey Heath system has incorporated the 5 Surrey Health and Wellbeing Priorities into our strategic plan as shared local objectives. The Surrey Health and Wellbeing Board priorities also set the framework for the Better Care Fund and have therefore supported alignment of our strategy and the Better Care Fund Plan.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

East Surrey CCG

Co-commissioning is a key enabler to the East Surrey CCG's Better Care Fund plans which focus on supporting and enabling people to remain at home, preventing avoidable hospital admission and improving hospital discharge through lower level care provision. Co- commissioning will ensure that consistency of care across the locality is maintained and/or improved, it will also provide for the local management of the care market with the potential for greater negotiating strength on cost and volume of contracts.

ESCCG has expressed an interest in co-commissioning primary care on the basis that plans should be developed with the Area Team over the next six months with an increased focus on governance in the first instance. The Area Team is fully aware of the commissioning intentions surrounding the Better Care Fund projects.

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Guildford & Waverley CCG

We consider the Better Care Fund (BCF) to be a significant catalyst for change and the opportunity to co-commission more primary care will strengthen this. As part of the process for accessing BCF funding, NHS Guildford & Waverley CCG and Surrey County Council will have to demonstrate that a number of national conditions are being met. These include seven day health and social care services to support patients being discharged and to prevent unnecessary admissions at weekends. Co-commissioning will strengthen the co-production of a whole system service delivery model and development of specifications that will set out the health and social care services required to meet the needs of our local population. Co-commissioning will enable the CCG to influence and inform cohesive incentives across the health and social care system.

We believe that co-commissioning primary care will allow the CCG to refine service quality, better engage with practices and patient groups, address health inequalities, and simplify the commissioning landscape for providers including primary care.

We see many benefits in taking on responsibility for elements of primary care commissioning which will enhance and align with the Better Care Fund commissioning intentions:

- Achieve greater integration and more cohesive out of hospital services
- Raise standards of quality, reduce variation and provide targeted improvement support for practices
- Enhance patient and public involvement in developing services
- Tackle health inequalities for targeted communities and more deprived areas.

Integration of health and care services - We will achieve greater integration of health and social care services through the development of a range of initiatives all of which will benefit from the flexibilities that a co-commissioning arrangement would provide.

Vertical integration - The G&W CCG Primary Care Plus+ Strategy sets out the ambition to vertically integrate Primary Care and community services into one service delivery model centred on the needs of practice populations. Vertical integration is defined as a means to encourage ownership of the whole system pathway. For example, GPs and practices own the delivery of services by virtue of community care being an extension of practice activities. This service

transformation will move the current system from a 3-tier to a 2-tier model with the emphasis of change to shift treatment from hospital to the community and closer to home as clinically appropriate. Using primary care co-commissioning will enable the commissioning of local primary care services that will align, enhance and complement the BCF model of care.

The major transformation in our Primary Care Plus+ Strategy will achieve the following:

- Vertical integration of community and primary care services into one service delivery model centred on the needs of practice populations through establishment of virtual practice teams (community services) who in partnership with primary care will own a joint set of clinical outcomes.
- Seven day working
- Extended opening hours

Reducing the amount of time people spend avoidably in hospital - The local health economy experiences some issues that the CCG is working closely with the Royal Surrey County Hospital to resolve. In particular, the ageing population requires community services to expand its current scope in terms of availability and delivery to prevent more avoidable admissions than ever before. The resulting impact on the Acute Trust is a reduction in excess bed-days and unplanned admissions that reduce income.

Although there has been a 15% reduction in the unplanned and emergency admissions, there has been an overall increase since 2009/10 in admissions for acute conditions that should not usually require hospital healthcare.

Hence, there is a need to counter this deterioration in the community through better, more integrated healthcare. Our Primary Care Plus+ strategy in tandem with the national direction regarding named GPs and extended opening hours will provide the wrap-around health and social care needed by people living with a long-term physical and/or mental health condition.

Access to the Highest Quality Urgent and Emergency Care - We aim to commission highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. As such, we are seeking to procure an innovative, high-quality, flexible out-of-hours primary care service (to start 1st October 2014) that has as its core aim integration with local health and social care services as well as with NHS 111.

Optimal episodes of care in hospital, in general practice and in the community - Rapid discharge is a key quality marker for the CCG. If patients do not need the full hospital resource to recover from illness we will look after them in the community. Responsive, better care will be provided through use of the Better Care Fund to integrate community services with social care and voluntary services so that patients feel fully supported to get back to independence at home.

Significant progress has already been made in supporting patients discharged from hospital, and preventing unnecessary admissions, with the establishment of a Better Care Fund Hospital Improvement Group (BCF HIG) with the Royal Surrey County Hospital NHS Foundation Trust, Virgin Care Ltd (community service provider) and Surrey County Council (social care provider).

North East Hampshire & Farnham CCG

The BCF plans in place aim to integrate our health and social care economy, offering local people easier access to services (closer to home and in community settings) and a smooth transition when their care needs need to be met by multiple providers.

The central role for primary care in delivering more integrated care and support resonates across

the CCG area and has underpinned our CCG decision to apply to co-commission primary care. A key principle of local integrated models has been that primary care service provision must change and adapt to be sustainable. In part the opportunity to co-commission will help to address the impact of an emerging challenge for our system to recruit sufficient General Practitioners, which historically was not a concern.

GP practices are aligning into networks to focus on shaping proactive integrated service models around their registered patients. The co-commissioning will assist us in achieving our outcome ambitions to:

- Secure additional years of life
- Improve quality of life
- Reduce the amount of time people spend avoidably in hospital
- Increase the proportion of older people living independently at home
- Increase the proportion of people having a positive experience of hospital services
- Increase the proportion of people having a positive experience of primary and community services
- Eliminate avoidable deaths in hospitals

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One of the key objectives of Integration and the Better Care Fund is to place GPs as fully engaged lead professionals in proactive multidisciplinary teams. Aspirations of co-commissioning incorporate integration models based on locality working where groups of GPs with common populations, issues and resources are working to develop a local service model with local stakeholders and care providers rooted in local communities.

Associated with the setup of integrated care teams, is a desire to investigate a more targeted approach to 7 day working to care for older people with complex needs aged over 75 years.

The alignment of metrics in the Better Care Fund with those associated with co-commissioning will demonstrate the impact of these two interdependent transformation elements through:

- A reduction in emergency admissions and A&E attendance
- A reduction in delayed transfers of care from hospital
- Fewer readmissions to hospital
- A shorter average length of stay for people admitted to residential and nursing homes
- Improved access to services through 7 day working
- Improved responsiveness in a time of crisis e.g. rapid response, intermediate care

Other measure will also be contingent on stronger integration for the population, specifically:

- Increase the diagnosis rate for people with dementia
- Increase the number of older people (aged 65 and over) receiving reablement services per 100,000 population

Co-commissioning will support the delivery of integrated models by giving the Clinical Commissioning Groups the ability to influence the future model of primary care service provision at a very local level. Once decisions about changes to service delivery models are made, the Clinical Commissioning Groups will be well placed to support primary care in making the necessary changes to operational models and contractual incentives.

Our current primary co-commissioning plans set out a statement of intention - that co-commissioning will allow us to progress the BCF plans further and at the scale and pace required. We feel that co-commissioning will enable us to progress conversations at a very local level. Once decisions about changes to service delivery models are made, the CCG can then support primary care in making the necessary changes, ensuring full alignment with BCF plans and priorities.

North West Surrey CCG

NHS North West Surrey CCG has submitted an expression of interest to deliver co-commissioning and this has been reviewed favourably. It is recognised that primary care is a key component in the delivery of proactive and pre-emptive health care, which is vital to the success of the integrated care programme and locality hubs.

Although unsuccessful, the CCG submitted an application to the Prime Minister's challenge fund which had full support of all 42 GP Practices in the NW Surrey locality. This plan first outlined our current vision of delivering physician led proactive care through locality hubs to the older population. Building on this commitment the CCG has been able to develop a local integrated health and social care model (Locality Hubs) to support the frail and elderly, with primary care and local GPs as the whole system leaders.

Local GP practices are aligning into Local Network Boards, chaired by a locality GP, to drive the shaping of this proactive integrated service model around their registered patients

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Surrey Downs CCG

The CCG expressed an interest in co-commissioning to the Area Team for all areas available and with a view to developing co-commissioning above and beyond the initial offer. This is in recognition that co-commissioning is a key enabler to the CCG's Out of Hospital Strategy and Better Care Fund plans which focus on supporting and enabling people to remain at home, preventing avoidable hospital admission and improving hospital discharge through enhanced lower tier care provision.

Co-commissioning will enable the CCG to improve the quality and scope of services available in Primary Care and give the Surrey Downs CCG assurance on the ongoing service provision commissioned over and above the core GP contract. Primary Care needs to undergo transformational change in order to work effectively at scale and pace - this is being encouraged locally through our Primary Care strategy and development of schemes which practices can deliver as Networks ie across individual GP surgeries

Surrey Heath CCG

General Practice is viewed as an integral part of the Integrated Care teams within Surrey Heath which will deliver much of the operational improvements in care delivery through closer working between agencies. At a local level the CCG is commissioning extended hours provision from their general practice providers through additional locally commissioned services. These services have been aligned with the planned improvements through the better care fund.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

In Surrey, the agreed local definition of protecting adult social care services is that:

- Funds for the protection for social care must be used for the CCG population from which the funding has come from
- Funds for the protection for social care cannot be used to fund local authority statutory functions or services
- Health and social care will agree jointly what specific services will be protected in each CCG area
- Joint monitoring, transparency and open book approach
- Dedicated commitment to transformation and integration at CCG level

Those CCGs that will be forced into a deficit position as a result of investing in the protection of social care and the wider BCF plan will also require NHS England and Governing Body approval to do so; this will be progressed to support the end of November timescale.

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ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Local schemes and spending plans will support the commitment to protect social care by ensuring that:

- Any contribution towards £25m is dependent upon clear implementation plans (with related impact assessments) agreed locally before end November 2014 and agreed risk share (to be agreed by end November 2014) against delivery of agreed metrics. If partners do not agree that plans produce the appropriate improved outcomes then a third party will be asked to arbitrate.
- An assumption that the Whole System Partnership Fund (existing Section 256 agreement) ceases from 1 April 2015 and then services are explicitly renegotiated at local CCG level
- A named social care lead with decision making authority and a dedicated finance lead to be part of each LJCG
- £25m payment would not be received as lump sum on 1 April 2015 and may be by 1/12th payment per month

In addition, and in recognition of the scale of change and delivery of benefits at the pace needed in the Surrey health and social care system, we have looked beyond these existing local joint plans to identify other services and funding streams amenable to integration and transformation in the future. This is based upon a shared commitment amongst members of the Board to work together in collaboration to achieve better health and social care outcomes for the residents of Surrey. The outcome from this work is a set of preliminary schemes that make up an enhanced Better Care Fund plan. These schemes are not in the scope of the agreed Surrey BCF pooled fund at this stage, but are described in Annex 3 to indicate our ambition for the future. These schemes provide the potential for scaling up the benefits described in the local joint plans, delivering additional benefits and protecting adult social care services.

A week-long 'hot house' workshop was held in September 2014 with participants from Surrey

County Council and Surrey's six Clinical Commissioning Groups. The 'hot house' looked for opportunities to go beyond the existing local joint Better Care Fund plans to join up local health and social care services in Surrey to:

- Keep people independent in their own homes for longer;
- Reduce hospital admissions and length of stay; and
- Make the level of savings needed across the system in 2015/16 and beyond.

The 'hot house' focussed upon elderly frail services (65yr+ including dementia), identified as the services with the most significant shared interest, the largest spend and thus opportunity to deliver benefits. The underpinning principles of the opportunities arising from the 'hot house' have been a system designed around the person in their natural community; one team empowered to deliver; inclusive and accessible local services; and integration with primary care. There are clear synergies between these opportunities and those set out in the local joint plans - they are intended to build upon and enhance the existing local joint Better Care Fund plans for 2015/16 and described under four headline schemes, make up Surrey's enhanced Better Care Fund.

The four headlines schemes which have been identified are:

1. Total Team
2. Whole system demand management
3. Mission 90
4. Call for Back-up

The potential total enhanced Better Care funding for 2015/16 is in the order of an additional c. £400m across health and social care – this is currently not part of the Surrey BCF pooled budget as further detailed modelling is required.

There is on-going work to develop these schemes over the next few months to confirm the expected savings and model the outcomes. This further work will include the agreement of financial and scheme details by the Local Joint Commissioning Groups. It is acknowledged that there is currently some overlap and duplication between existing local schemes and the four enhanced Better Care Fund schemes – this will be addressed as the local schemes are enriched over the coming months to take on board to enhanced Better Care Fund schemes ambition.

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iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

In 2015/16 the total amount from the BCF that has been allocated for the protection of adult social care services will be £25m.

We have identified £2.563m revenue and a further £0.946m capital of the Surrey Better Care Fund in 2015/16 to support the implementation of the new Care Act duties.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The County Council is taking a co-design approach with is partners to ensure Surrey is ready to meet its new duties under the Care Act 2014. This includes:

- Reviewing Surrey's information, advice and advocacy strategies

- Reviewing how we assess eligibility and help plan support to incorporate a 'strength based approach'
- Reviewing support offered to carers, particularly young carers, to enable them to sustain their caring role.
- Exploring a range of options to meet the projected increase in demand for assessments from self-funders, including the potential for commissioning 'trusted assessor' organisations and online self-assessment.
- Providing a public facing portal so residents can understand how best to meet their support needs and to progress towards the cap.
- Designing and implementing care accounts for self-funders.
- Reviewing how we can ensure vulnerable adults in Surrey's prisons are supported.
- Testing whether we need to expand our current independent advocacy arrangements to ensure that anyone who experiences substantial difficulty communicating their wishes, irrespective of their mental capacity, can access an independent advocate.

The Care Act Implementation Project is overseen by the Adult Social Care Implementation Board, a multi-agency partnership including senior leaders representing Adult Social Care, user-led organisations, health, private providers and district and borough authorities. Progress is regularly reported to the County Council's Adult Leadership Team, and progress updates are given to the Health and Wellbeing Board, Cabinet, the Corporate Leadership Team and the Adult Social Care Select Committee.

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v) Please specify the level of resource that will be dedicated to carer-specific support

£2.463m of the Surrey 2015/16 Better Care Fund will be dedicated to carer-specific support. It is acknowledged that some associated contracts and costs which are currently paid for by CCGs will transfer with these funds. The carer-specific support will enable Surrey to continue its commitment to Carers Breaks services. These services are designed to promote carers independence and wellbeing; are delivered through home based breaks services including in end of life situations and also through breaks payments approved by GPs.

In addition, £0.72m of the funding identified to support implementation of the new Care Act duties in the Surrey 2015/16 Better Care Fund, will be used to respond to the new duties to help carers arising from the Act. This funding will be used to increase capacity in independent preventative carers services to reduce carers needs for support from statutory services (including for young carers) and to support carers posts in social care teams.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

No differential impact is intended or expected to arise.

b) **7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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

Progress has already been made, with for example:

Adult Social Care	• 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.
Surrey Heath CCG	In preparation for the Better Care Fund in 2015/16 Surrey Heath CCG has agreement from general practice, community, mental health and social care providers to deliver an 8am - 8pm core service (Monday – Friday) as part of an integrated care team. These services will be delivered from three practice based hubs. The LJCG is committed to the delivery of 7 day services in line with the needs of our community.
North East Hampshire & Farnham CCG	North East Hampshire and Farnham CCG are already implementing 7 day working arrangement with key providers such as our local acute Trust (Frimley Park Hospital) in ensuring there is greater consultant cover at evenings and weekends, and also in social care with reablement. Further schemes are being developed to bolster seven day services in order to support patients being discharged and to prevent unnecessary admissions such as the over 75s Primary Care development scheme, our Operational Resilience and Capacity Planning, and the amendments to service specifications with our community providers.

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

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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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.

Surrey County Council Adult Social Care already has the NHS number into the Adults Integrated System (AIS) and this is refreshed on a monthly basis as part of business as usual.

ii) Please explain your approach for 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.

The Health and Social Care Integration programme, as part of the Surrey Public Service Transformation Network, has identified 4 key enablers, in part to support the Better Care Fund. One of these enabler projects is Effective Data & Information Sharing. The strategic aim of this project is to put effective data and information sharing arrangements in place across the Surrey health and social care system, so as to enable health and social care professionals to work collaboratively to deliver an enhanced and integrated model of community based health and social care.

The deliverables for this project will be:

- Shared understanding amongst information governance leads and Caldicott Guardians in partner agencies across the Surrey health and social care system, about the importance of data and information sharing, the barriers and how these will be overcome, by no later than March 2015.

- Jointly agreed Surrey data and information sharing protocol(s) in place between health and social care partners participating in phase 1. This will build upon and be consistent with the Surrey MAISP, the Data Protection Act and Human Rights Act, Caldicott 2 and guidance from the Information Commissioner's Office (ICO), by no later than March 2015.
- Active sharing of data and information between health and social care partners participating in phase 1, from April 2015.

To enable social care to participate as key partners in the sharing of data and information, the following deliverables also need to be completed as part of this project:

- Up-to-date consent to share records for all open social care records, to enable Surrey County Council to give access to third party organisations such health partners, by no later than March 2015
- Policy for responding to third-party requests for direct access to, and data extracts from, social care systems, by no later than March 2015.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

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

There is an existing Surrey Multi-Agency Information Sharing Protocol (MAISP) and a Surrey MAISP User Group. The MAISP is an agreed set of principles about sharing personal or confidential information. It enables each organisation signed up to the protocol to understand the circumstances in which it should share information and what its responsibilities are. The Surrey MAISP has been developed in partnership by representatives from Surrey's County, District and Borough Councils, the health service and Surrey Police.

The Surrey MAISP does not replace context-specific protocols, but provides a framework within which they can all operate. It provides both a common understanding for all the agencies in Surrey to work to and is recommended for use as a template for situations where there is no context-specific protocol. Organisations that sign up to an approved context-specific information sharing protocol automatically become signatories of the Surrey MAISP, the over-arching protocol and are bound by its principles.

The processing (including obtaining, recording and sharing) of personal and confidential data can only be done when permitted by law ie with the consent of the person concerned, when there is a statutory duty to do so, when required by court order, or when the processing can be shown to be in the 'public interest'. The processing must also meet the requirements of the Data Protection Act and the Human Rights Act. Data sharing across the health and social care system must comply with the law. This can be best achieved by obtaining specific consent from the person at the outset and periodically reviewing consent when the data is revised.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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

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ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

CCG	Risk Stratification	Estimated % at high risk of admission	Joint Care plan
East Surrey CCG	John Hopkins Adjusted Clinical Group (ACG)	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 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 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 practice with MDT	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 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	John Hopkins	In North East Hampshire and	GP practices are implementing

CCG	Risk Stratification	Estimated % at high risk of admission	Joint Care plan
Hampshire and Farnham CCG	Adjusted Clinical Group (ACG)	Farnham CCG, both the Community Nursing Teams and GP Practices use the John Hopkins Adjusted Clinical Group's algorithms tool. GPs have been incentivised to use data to predict high intensity users and stratify risk in relation to people with Long Term Conditions at risk of hospital admission. GP practices currently review the agreed % of their most at risk population each quarter and use multi-disciplinary team reviews (including adult social care professionals) to identify those adults at high risk of hospital admission. The current incentive schemes support the approach. At risk individuals are reviewed and clinical teams are working towards all at risk individuals having a joint care plan and accountable professional (GP lead). In addition dementia diagnosis has been targeted to give people are their carers access to community based preventative and support services.	an agreed care plan for 10% of identified patients, co-ordinated through an accountable lead GP
North West Surrey CCG	SOLLIS	North West Surrey has used the risk stratification tool SOLLIS, and by incorporating the Unplanned Admission Direct Enhanced Service, practices have identified the top 2% of our population determined as high risk. The software makes use of all GP and secondary care diagnoses, all GP prescriptions, and key operations in secondary care over a 12 month period. It also recognises and makes use of long-term conditions from the longitudinal health record. This element recognises around 200 different conditions and	The Local Joint Commissioning Group (LJCG) 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 The LJCG provides the professional accountable lead & governance to support the management of people at high risk of hospital admission as part of a joint process to assess risk, plan and co-ordinate care.

CCG	Risk Stratification	Estimated % at high risk of admission	Joint Care plan
		incorporates demographic (age and sex) information about individuals to build the ACG model and determine level of risk.	
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	EMIS IQ risk stratification tool implemented by Sept 2014	Top 2% of population over 18 years.	All out general practices are participating in a National unplanned hospital admissions enhanced service (DES). This requires the top 2% of the population over 18 years and at risk of admission to have a co-ordinated care plan. The integrated care teams will support the GP as the accountable lead professional

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iii) Please state what proportion of individuals at high risk already have a joint care plan in place

CCG	Proportion of individuals at high risk with a joint care plan in place
East Surrey CCG	Systems are in place for joint sharing and collation of care plan data. There are plans in place to ensure that 2,500 high risk patients have integrated care plans which are available to health and social care teams including 999, NHS 111, GP Out of Hours and Community Services.
Guildford and Waverley CCG	As part of the Quality Premium in 2013/14, 181 Proactive Anticipatory Care Plans were achieved. Primary Care continue to implement this scheme with their developing 'at risk' registers. The target for 2014/15 is 206 PACE plans to be in place.
North East Hampshire and Farnham CCG	As part of the 2013/14 Risk Profiling Care Management Scheme DES 220 joint care plans were put in place for high risk patients across the CCG population. As part of the 2014/15 Proactive Care Programme (formerly the Avoiding Unplanned Admissions Enhanced Service) our CCG will have 2% of the highest risk patients within our population with a joint care plan in place by October 2014 (equating to 4,400 patients).
North West Surrey CCG	During 2014/15 the CCG has incentivised GPs to develop in partnership with their patients 7,000 care plans by 30 September 2014.
Surrey Downs CCG	As part of the 2014/15 Proactive Care Programme 2% of the highest risk patients, following risk stratification, will have a joint care plan in place by December 2014. In addition to this, those patients who may not have been identified via that route but still requiring a multi-

CCG	Proportion of individuals at high risk with a joint care plan in place
	disciplinary approach, will have a joint plan via the integrated teams. This will be more clearly definable by quarter 4 of 14/15.
Surrey Heath CCG	As part of the GP Unplanned Hospital admissions DES 2% of the highest risk patients will have joint care plans in place by the end of September 2014. This data is unlikely to be available until towards the end of the year. In addition additional joint care plans may be identified through the Integrated Care Teams.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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	NHS North West Surrey has an extensive infrastructure to enable patient and public engagement at practice, locality and CCG level. Complimentary to this, we are developing processes that enable randomised and representative patient feedback from our population and local community, building on processes already in place with providers and local authorities developed with strong representation from Healthwatch Surrey, borough councils and voluntary sector. The CCG's strategic plan commits to a significant public listening process as we develop and finalise plans for changes to pathways and service delivery. We have a programme of events designed to support engagement with 'harder to reach communities' commencing in Autumn 2014, where representatives from carers, gypsy, traveller & Roma groups, lesbian, gay, bi-sexual and trans-gender communities supported by our equality advisor will be in attendance. The feedback we received from our GP patient participation groups across our three localities advised what were the important themes: • Alternative options to attending A&E • Extended opening hours of GP surgeries, enabling more appointments. An improved out of ours service • Shared Care information • Education and Information sharing for Patients • Improve communication between all sectors These themes form a fundamental part of the model and design for our integrated care programme and locality hubs.
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

	organisations and members of the public. Making it Real events with 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.

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b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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.

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. The North West Surrey CCG Better Care Fund return has been developed through the following process: **Acute hospital services** Ashford and St. Peter's Hospitals NHS Foundation Trust is the single acute hospital trust within the CCG's boundaries, operating on two sites (Chertsey and Ashford). The CCG also commissions acute hospital services from a number of other providers including: • Royal Surrey County Hospital NHS Foundation Trust • Frimley Park NHS Foundation Trust • St. George's Healthcare NHS Trust (specialist services) • Local independent sector hospitals including Woking Nuffield, BMI Runnymede & Princess Margaret Windsor **Community health services** Virgin Care Ltd has been the main provider of community health services across North West and South West Surrey since 1 April 2012, as well as delivering some county-wide services, such as prison

	healthcare and sexual health. Since April 2013, North West Surrey CCG has taken the lead commissioner role for the Virgin Care community contract, meaning that we manage this contract on behalf of other regional organisations. This includes all other Surrey CCGs, two NHS England Area Teams (Surrey & Sussex and Kent & Medway) and Surrey County Council for Children's Services and Public health. **Mental Health services** Surrey and Borders Partnership NHS Foundation Trust (SABP) provides mental health services to our local population. The Trust is the leading provider of specialist mental health and learning disability services for people of all ages in Surrey and North East Hampshire. It also provides psychiatric liaison at Ashford and St. Peter's Hospitals and community mental health input to the Virtual Ward teams, staffed by Virgin Care. **Ambulance services** In North West Surrey, ambulance, patient transport and NHS 111 services are provided by South East Coast Ambulance Service (SECAmb). Since April 2014, our CCG has managed this contract for the whole of Surrey, acting as lead Associate Commissioner for Surrey within the regional contract covering Kent, Surrey and Sussex.
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.

ii) primary care providers

East Surrey CCG

East Surrey CCG has recently begun work with First Community Health Care to realign services to be more closely aligned to GP practices and to operate in partnership as multidisciplinary teams. There is a steering group in place with dedicated project management to ensure this work is successfully implemented. The Practices Commissioning Committee has representatives of all GP practices within East Surrey and this is the vehicle for both the development of plans as well as reporting against progress.

Guildford & Waverley CCG

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The Terms of Reference for the BCF Local Joint Commissioner Group in Guildford and Waverley includes Primary Care representation. This group has oversight of the local development, management, delivery and performance management of plans.

Primary Care is also represented on the BCF Hospital and Implementation Group and BCF Delivery and Implementation Group to manage delivery of initiatives to support early discharge and admission avoidance.

A frailty forum is in place with primary care to address interface delivery issues related to the care of the frail and vulnerable by emergency primary care, social care, community and acute providers.

We continue to undertake regular practice visits to support the delivery of the frailty initiatives.

Primary Care has been involved in the workshops in developing the concept of an ICO.

A telehealth event has taken place with primary care to raise awareness and increase participation in the use of telehealth. Further engagement is currently underway to raise awareness of the behavioural motivational coaching scheme that is being launched.

The CCG has engaged with a range of providers to map service provision for patients with dementia, their families and carers.

Going forward, we will be establishing an end of life strategy group to map out current provision and review the end of life pathway in preparation for a new end of life integrated service model. Primary care is working in partnership with care homes to facilitate early supported discharge.

A piece of work is underway with primary care, social care and borough councils to review opportunities to recruit care workers in Guildford and Waverley area to support early supported discharge.

North East Hampshire & Farnham CCG

NEH & F CCG has begun the engagement/co-design process with all its primary care providers using a range of approaches to engage and involve them in the co design process for the Better Care approach. These include:

- A King's Fund facilitated primary care event (held locally in December 2013) to determine: What is the model of care we need in this area for the individuals at greatest risk? and

(crucially), how do we make it happen?

- GP Forum Workshops
- Clinical leadership of specific work streams and dedicated involvement in specific programmes eg mental health, diabetes, respiratory medicine, cardiovascular care, end of life care etc.
- System Resilience Boards and Unscheduled Care working groups
- Co-design of investment in transformation schemes for enhancing primary care
- Scoping the concept of co-commissioning developments

The outputs from these approaches have allowed the CCG to identify key priorities which have been incorporated into the CCGs five year strategy and BCF/Integration implementation plans.

North West Surrey CCG

As members of our Governing Body, primary care providers have and continue to be intrinsically involved in the development and actuation of commissioning plans to support and deliver the overarching operating plans supported by the Better Care Fund. Engagement is maintained and feedback received through locality stakeholder meetings scheduled throughout the year and the bi-annual Council of Members meetings.

Each locality has Patient Participation Groups which feed into the stakeholder meetings and support specific programmes of work alongside the development and review of core commissioning.

Surrey Downs CCG

Surrey Downs CCG is currently engaging with CSH Surrey, the major community health provider in the area and SABP in co- designing the frailty pathway and as a result the integration of services.

There have been several modelling workshops held with CSH Surrey, the main Community Health provider and Surrey County Council, in order to co-develop and design the integrated model. As a result of this work, regular update reports have been provided to the local Transformation Board, with whole system membership as well as to the Local Joint Commissioning Group.

In addition, drafts have been sent to Primary Care providers for their input and comment.

Within each of the primary care localities the SD CCG has held engagement workshops with GP's, CSH Surrey clinical locality managers and SCC adult social care managers. All contributions have been submitted as part of the co-design and co-production process

Surrey Heath CCG

Surrey Heath CCG has begun the engagement/co-design process with all providers - Virgin, SABP, voluntary sector, and primary care. The engagement that has already taken place around the development of the integrated care teams is detailed below:

Engagement Activity Undertaken &Planned	Stakeholders Involved	Date

Individual provider engagement events – Integrated Care Teams	General practice Community nursing (Virgin Care) and general practice Community nursing (Virgin Care) Community mental health (SABP and voluntary sector) Voluntary and faith sector Adult social care Acute interface (FPH) Nursing and residential home forum	11 Feb 7 March 18 March 17 March 31 March 3 April 11 July
Multi-agency engagement events - Integrated Care Teams	Options appraisal (all providers see above) System wide workshop (see above plus patients)	11 April 13 May
Multi-agency engagement – Integrated Care Teams On going governance/engagement structure	All providers (SABP, Virgin Care, Surrey County Council, voluntary sector, FPH) ICT Steering Group ICT Project Group	3 June, 7 July 16 June, 18 July, 18 August
Additional engagement events acute provider (FPH) in conjunction with NE Hants and Farnham CCG and Bracknell and Ascot CCG. NOTE: FPH relates to 3 BCF plans.	FPH	3 April

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iii) social care and providers from the voluntary and community sector

Social care and providers from the voluntary and community sector have been engaged in the development of plans through the five local Transformation Boards. Throughout 2013/14, providers were involved in developing an integrated vision for out of hospital care in each local area through the relevant local Transformation Boards. Whole systems engagement events were held across Surrey during November and December 2013, which included 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.

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 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 the voluntary sector and with user and carers groups through the Adult Social Care Implementation Board in January 2014. Further discussions and engagement activity is planned with providers from the voluntary and community sector during 2014/15 as part of detailed local planning.

East Surrey – The voluntary sector is engaged in the development and delivery of local ESCCG BCF plans.

Guildford & Waverley - The CCG Governing Body has approved the Communications and Engagement Strategy which sets out the strategic direction and practical steps for capitalising on existing ways to engage people with Health and Well Being Board partners, through Practice Patient Participation Groups and Community and Voluntary Sector interest groups. The CCG recognises, Healthwatch will have a key role to play and the CCG looks forwards to developing the relationship with Healthwatch as a key partner in patient and community engagement, together with Overview and Scrutiny members of the local Councils.

G&W CCG continue to work through collaboration with providers and service users to establish levels of demand and capacity requirements. The Initial commissioning intentions have been drafted and will be presented to the Clinical Commissioning Board GB September 14. These will continue to be worked on and engagement with neighbouring CCGs through the Commissioning Operational Group to realise where there maybe synergy and efficiencies through commissioning additional services over and above the existing collaborative commissioning arrangements.

North East Hampshire & Farnham - The voluntary and third sector are currently represented on our Integrated Care Commissioning Group. We are currently working with this sector to map and develop a workforce development programme to support the changes required to deliver integration and transform patient care. We are collaborating with the voluntary sector to design and deliver our integrated care service model and have asked the voluntary sector to take a lead role in 2 key areas of our work – firstly workforce efficiency analysis and the roll-out of locality teams around general practice.

North West Surrey - North West Surrey are building processes and opportunities to increase and regularise the engagement and incorporation of voluntary and community sector providers as part of North West Surrey's planning processes, following their involvement with the development of the Strategic Commissioning Plan during the whole system events in 2013 and subsequent plan refreshes.

Specific forums have been established between social care and voluntary sector organisations & ourselves to build and maintain relationships, whilst establishing a shared agenda for local planning with increased understanding of the parties' respective drivers and remits. Additionally, engagement sessions are being held with our main community provider to achieve the same. These organisations link with the Council's Adult Social Care Implementation Board.

We have conducted two whole system workshops during 2013. In June 2013, 120 participants attended a workshop and from this local priorities emerged. Feedback was sought again during October 2013 in relation to the change proposals and emerging objectives for these priorities. Between these two dates, health and social care provider lead clinicians continued to be engaged with developing the priorities further.

Surrey Downs - Surrey Downs CCG is currently engaging with CSH Surrey, the major community health provider in the area and SABP in co-designing the frailty pathway and as a result the integration of services.

There have been several modelling workshops held with CSH Surrey, the main Community Health provider and Surrey County Council, in order to co-develop and design the integrated model. As a result of this work, regular update reports have been provided to the local Transformation Board, with whole system membership as well as to the Local Joint Commissioning Group. In addition, drafts have been sent to Primary Care providers for their input and comment.

Within each of the primary care localities the SDCCG has held engagement workshops with GP's, CSH Surrey clinical locality managers and SCC adult social care managers. All

contributions have been submitted as part of the co-design and co-production process.

Surrey Heath - Surrey Heath CCG has begun the engagement/co-design process with all providers - Virgin, SABP, voluntary sector, and primary care.

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c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

East Surrey

The BCF schemes have been developed to focus on integration of services to achieve seamless care at all points in the care pathway. The impact for SASH will be a joined up approach for patients which will enable greater efficiency and collaboration between services. The impact for SASH in activity terms is set out below:
6.5% non-elective activity reduction in 15/16
7% non-elective activity reduction in 16/17
Reduction in delayed transfers of care – to be quantified
The above will be achieved through locally developed plans to integrate health and social care within our proactive care teams, multidisciplinary teams and integrated discharge teams. The discharge to assess developments coupled with CHC service reviews will also facilitate the reduction in delayed transfers of care. All of this work has been developed collaboratively with local providers through the well-established "Front Door" programme and the recently launched Discharge to Assess programme.
The Surrey wide hot house set out a wider piece of transformation work and local implementation plans will now be developed to build upon local workshops, programmes of work and the operational resilience plans that have been done at East Surrey CCG level. The local work will include business case development, workforce reviews, IM&T reviews and estates reviews to support the full integration of services.

Guildford & Waverley

The overall implications are a reduction in spend in the acute sector.

All of the BCF schemes are enablers to overarching QIPP plans that contribute to a reduction in A&E attendances, unplanned admissions, and excess bed days as described in the Primary Care Plus+ Business Case.

A contract agreement for 2014/15 is in place with RSCH to reduce activity and aligned savings against non-elective admissions as part of joint delivery of schemes. Local provider plans for 2015/16 are consistent with the BCF plan.

North East Hampshire & Farnham

We recognise that currently the services that people need and want do not align. We agree that we need to see a fundamental shift in the way urgent care is provided. This means changing both what services are provided and where services are available, so that interventions and support will be co-ordinated around individual needs and delivered as close to people's homes as possible, minimising disruption and inconvenience. People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities to maximise their chance of survival and good recovery.

To be successful we will require a level of investment in primary, community and social care services to meet the challenge, shifting some acute hospital based planned activities to safe, alternative community based services.

Our CCG has developed trajectories for planned care and non-elective activities and these are being agreed with providers. As part of this work, commissioning models will clearly define access criteria to evolve to meet changing population needs, moving away from episodic care to pathway / outcome based. Some of these changes require pump priming and should lead to increased efficiency and productivity between health and social care.

We are planning for a reduction in non elective admissions over the next three to five years. This will have an impact on the acute service capacity.

Whilst we have begun to articulate our plan further work is still needed to reflect the impact on admission rates more clearly, not least because of the plans and proposals of the acute care providers as sovereign entities and the impact of current system payment mechanisms and incentives. Importantly CCGs have signalled to providers the changes that will result from the BCF implementation. Collectively the CCGs in Hampshire are taking forward options for different payment and reward mechanisms, enabled by the current exercise being undertaken by Monitor which should have a positive impact on our Surrey population in Farnham. Structural changes within and around Surrey such as the Frimley Park Hospital NHS Foundation Trust acquisition of Heatherwood and Wexham Park Foundation Trust could have an impact.

At this stage we are working with all the Acute and Community Providers to assess the impact of changes and agree how we will commission 7 day services that wrap around an individual in the community as the norm. Initial estimates will be revised to reflect emerging evidence of local system change.

North West Surrey

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.
The CCG has modelled the provider impact of a 3.5% non- elective impact and a 15% reduction in non-elective excess bed day reduction. These impacts have been aligned with the main acute trusts Long Term Financial Model.
The CCG activity is currently above the 2008/09 threshold and as a consequence in 15/16 the majority of income reduction will reduce the CCG threshold reserve.

NW Surrey CCG: Better Care Fund Provider Impact 2015/16

	Ashford St Peters		Royal Surrey CH		Frimley Park		Sub Total		Other		NW Surrey	Total		BCF Perform.
Planned 2014/15	Activity	Expend	Activity	Expend	Activity	Expend	Activity	Expend	Activity	Expend		**Activity**	**Expend**	@£1490
Emergency Short Stay	2,212	1,680,682	1,013	782,241	164	62,088	3,389	2,525,011	441	328,251		**3,830**	**2,853,262**	
Non Elective	16,944	42,523,854	2,025	2,620,841	1,904	1,975,624	20,873	47,120,319	2,713	6,125,641		**23,586**	**53,245,960**	
Excess Bed Days Emergency	8,632	2,249,947	914	233,731	1,004	131,480	10,550	2,615,158	1,372	339,971		**11,922**	**2,955,129**	
Non Elective Threshold		-3,036,000		-421,012		-616,940		-4,073,952			4,073,952	**0**	**0**	
Total		43,418,483		3,215,801		1,552,252		48,186,536		6,793,863	4,073,952		**59,054,351**	
Better Care Fund Reduction 2015/16														
Emergency Short Stay	-77	-58,824	-35	-27,378	-6	-2,173	-119	-88,375	-8	-5,744		**-126**	**-94,120**	188,224
Non Elective	-593	-893,001	-71	-55,038	-67	-41,488	-731	-989,527	-47	-107,199		**-778**	**-1,096,725**	1,159,281
Excess Bed Days Emergency	-1,295	-337,492	-137	-35,060	-151	-19,722	-1,583	-392,274	-24	-5,949		**-1,607**	**-398,223**	
Non Elective Threshold		861,345		63,068		42,847		967,260			-967,260	**0**	**0**	
Total		-427,972		-54,408		-20,536		-502,916		-118,893	-967,260		**-1,589,068**	1,347,505
Assumed Reduction: 3.5% Activity + 15% Excess Bed Days, Non Elective Price 60%														
Planned 2015/16 Post BCF														
Emergency Short Stay	2,135	1,621,858	978	754,863	158	59,915	3,270	2,436,636	433	322,507		**3,703**	**2,759,143**	
Non Elective	16,351	41,630,853	1,954	2,565,803	1,837	1,934,136	20,142	46,130,792	2,666	6,018,443		**22,808**	**52,149,235**	
Excess Bed Days Emergency	7,337	1,912,455	777	198,671	853	111,758	8,968	2,222,884	1,347	334,021		**10,315**	**2,556,905**	
Non Elective Threshold	0	-2,174,655	0	-357,944	0	-574,093		-3,106,692			3,106,692	**0**	**0**	
Total		42,990,511		3,161,393		1,531,716		47,683,620		6,674,971	3,106,692		**57,465,283**	

Surrey Downs

Surrey Downs CCG has modelled it's Out of Hospital Strategy with Epsom Hospital which is predicated on flat, minor negative growth over the next 5 years. Prior to the CCG's decision to withdraw from the Better Services Better Value programme Epsom Hospital assured the CCG's Governing Body that is a viable organisation on this financial scenario. However, 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 BCF 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.

Our recent audit work with Epsom Hospital shows a high proportion of patients require acute medical assessments and beds, driven by varying quality of care in home settings and increasing acuity of illness. The key challenge is to enable earlier discharge from hospital as a significant number of patients are fit enough to be discharged from acute environments (67% in one audit) but are delayed for key reasons: availability of IVs in the community; social and practical problems including continuing care; availability of daily home therapies and availability of community beds.

The emphasis on improving the continuing care assessment process, discharge to assess, preventing avoidable admissions and reducing length of stay is anticipated to have the following impact:

- **Beds usage -** Higher throughput of patients with lower numbers of admissions and shorter lengths of stay in medical beds
- **Same day assessments.** These will be off-set by increased levels of same day medical assessments and packages of care for repatriation home, with follow-up visits for repeat treatment, assessment and observation
- **Less readmissions** - Lower rates of unnecessary readmissions to hospital beds though these improved care packages that promote self-care and independent living
- **Transport** – Increased reliance on community and personal transport and parking by more day visits and less in-patient medical spells (and lower parking fees)
- **Multi-disciplinary teams** - Increased need for Consultants and Specialist Nurses to work as part of multi-disciplinary teams, working into and within the community, to enable general practice and community teams to manage higher levels of medical acuity
- **Information** – Increased reliance on integrated information systems, assessments and knowledge of care packages before the patient arrives for medical treatment in assessment units
- **Costs** - Reduced revenue from longer stay medical admissions and length of stay (beds) but also reduced costs from fluctuating medical bed capacity, such as escalation wards dependent on bank staff.
- **Estate** - The acute site would develop more multi-disciplinary spaces with medical beds at its centre, alongside community beds and integrated teams, with more organisations on site working as part of an integrated model of care.

Mental health services will be protected so that people vulnerable members of our community are not marginalised and prevented access from 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.

Surrey Heath

The CCG has been explicit with its acute provider that the implication of the BCF is an overall reduction in acute activity and spend supported by the development of more robust community services. There continues to be a lack of consistency in the planning assumptions being made by the commissioners and the acute provider. The CCG will be working with its partners to undertake more detailed modelling as part of the system's Operational Capacity and Resilience Plan. It is also holding an executive to executive meeting to detail its BCF plans to provide additional assurance on delivery. There is a recognition that the shared objective is sustainable local health and social care economy and high quality care.

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Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Local Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

East Surrey CCG

Scheme ref no.
ES1 (Whole system 3,6,21,23,26)
Scheme name
Enabling People to Stay Well
What is the strategic objective of this scheme?
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 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 **3.** **Enabling Planned Access to Services** – Reducing the number of patients that require urgent access to services will enable clinicians to better plan access to acute care. Access will be planned, quick and appropriate for the condition. Unnecessary hospital stays will be reduced and closer working relationships between primary/ community care and acute colleagues will be increased. 4. **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 **5.** **Contractual Levers as an enabler to change** – better contract management will enable efficiencies to be achieved throughout health and social care. There will also be opportunities for outcomes based commissioning, use of alternative tariffs and joint working to develop commissioning arrangements to support more integrated care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Our Care Pathway Transformation Programme considers the whole patient pathway provided in the diagram below:

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For each step of the pathway we have developed initiatives to enhance service offerings, integrate care, increase use of voluntary sector and focus on patient outcomes and experience. We have developed our schemes through a series of workshops with local acute, community, primary care, mental health, voluntary sector, health and social care partners. Our workshops have resulted in the joining together of already established projects along with the learning gained from the hot house clinics to create a whole programme of work aimed at achieving seamless care in the right setting.

1. **Enabling people to stay well**

The care pathway transformation programme will deliver this by:

- 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 and engaging voluntary sector organisations in the delivery of this
- Creating dementia friendly communities
- Increasing the awareness of services through better signposting

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
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**

The care pathway transformation programme will deliver this by:

- 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. These teams will work as single multidisciplinary teams with shared workforce plans, shared information sharing platforms and will work collectively to manage the whole of the patient pathway.
- 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 and ensuring that this person reviews the patients care plan on an ongoing basis
- Providing a single patient centred care plan, which is electronically accessible to all relevant health and social care professionals – currently to include 999, GP OOH and NHS 111 – this will be broadened
- 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
- Reviewing the use of Community Equipment, Occupational Therapy and the reablement team to ensure they are part of a wider multidisciplinary team operating out of primary/ community health and social care
- Making the best use of telecare, telehealth and an AA style service which will enable people to manage their own conditions seeking help as and when is appropriate.

- Increased use of voluntary sector to aid a 10% “shift to the left” in healthcare ie reduce the number of people accessing care at the highest end of the spectrum by bolstering support at the lower end.

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

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3. Enabling Planned Access to Services

The care pathway transformation programme will deliver this by:

- Ensuring the multidisciplinary team have direct access to the appropriate services and clinicians and are able to plan care without long lead in times.
- Commissioning care at the right price by increasing accessibility for primary and community care for diagnostics and expert advice from acute providers without paying for inpatient admissions.
- Working with acute providers to increase patient flow and supporting earlier discharge. This would involve closer partnership arrangements between acute hospitals and community bed provision through the use of separate tariffs and subcontracting arrangements

4. **Enabling people to return home sooner from hospital**

The care pathway transformation programme will deliver this by:

- 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
- Delivering Discharge to Assess model of care including rapid response, occupational therapy, reablement, telecare, home from hospital, equipment, transport all working together for the early supported discharge for patients at the point of assessment - building upon best practice developed through systems such as the Sheffield Model.
- Assessing patient needs at the point of admission to ensure the correct services are lined up for discharge – this might include dementia services, mental health 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

5. Contractual Levers as an enabler to change

The care pathway transformation programme will deliver this by:

- Reducing social care nursing fee exceptions
- Reducing Continuing Healthcare fee exceptions
- Community Health PTS savings by jointly procuring PTS services with Health services

Supporting all of the above will be cross cutting pieces of work such as communications and engagement, technology, contracts, workforce review etc which will support the delivery of the programme.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

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The CCG and SCC will commission these services from a consortium of established providers with a track-record of delivering innovative, proactive services. The consortium will include:

- Voluntary sector providers including Red Cross
- Surrey and Sussex Health Care NHS Trust
- Surrey and Borders Mental Health NHS Foundation Trust
- Surrey County Council
- First Community Health and Care
- GP practices within East Surrey

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Our case for change sets out the key drivers for our pathway transformation; some examples are provided below:

- High prevalence of some clinical conditions which could be reduced through prevention programmes
- Potentially low levels of diagnosis for some clinical conditions
- Increasing aging population with co-morbidities and long term conditions
- Fewer people than comparator groups feeling supported to manage their condition
- High rate of potential years of life lost to causes considered amenable to healthcare (compared to Surrey)
- Low levels of self directed support
- Low levels of patient staying at home 91 days after reablement
- Poor access information about services
- Poor experience for carers on basis of quality of life, services received and being involved in patient care
- High levels of delayed transfers

In addition to the above, local knowledge has contributed to the development of the programme in order that known issues can be addressed.

The impact of the scheme has been quantified at a Surrey wide level as part of the "hot house" approach although this now needs to be worked up again in a bottom up approach; this will ensure that the impact of the whole programme is attributable to various parts of the transformation and is realistic whilst still being ambitious. A date has been arranged in October 2014 to review the impact of each of the component parts of the BCF programme within East Surrey.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Saving stream	ES CCG
Reduce social care nursing fee exceptions by 50%	188
Reduce CHC fee exceptions by 50%	44
More effective procuring of reablement service - 30% saving in SCC reablement service cost	499
5% saving on patient transport in Community Health provider contracts	45
Renegotiation of the hospital tariff for zero length stay and unbundling of community bed discharge tariffs	322
Optimisation of care pathway - 10% shift down care settings	1,078
5% reduction in home care / district nurses contacts	321
6.5% reduction in hospital admissions	967
Diversion from social care - reduce demand from 6% to 3%	244
Integrated team efficiencies	295
Joint approach to reablement & rehabilitation services	469
Efficiencies in support & back office costs	110
Reduction in existing Whole Systems Partnership commitments	132
	4,715

East Surrey supports the outputs developed by the Hot House and plan to implement savings in the areas outlined above. It should be noted however that these benefits are still under discussion and have not been approved at a Local Joint Commissioning Group Level. Following the development of further detail with our plans in October we anticipate a greater level of granularity of where savings will be generated as a result of the wider transformation programme.

In addition to the above we expect to see improvements in patient experience, improvement in patient outcomes, reductions in non-elective activity, reductions in delayed transfers of care and fully integrated teams resulting in workforce savings.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The BCF metrics will be used at a high level to report on the success of the programme and to hold all partners to account on delivery. Locally there will be additional metrics which each service will be responsible for delivering. If BCF targets are not met it will be these data sets used to hold organisations to account for non-delivery. Each part of the transformation programme will have targets which will be based upon monthly achievement. The targets will be a combination of budgetary, quality and activity metrics.
What are the key success factors for implementation of this scheme?
Ensuring all local partners are engaged in developing the programme of work Ensuring local sign up to the targets and the methodology for capturing the metrics Ensuring all partners hold each other to account and work collaboratively to make the programme work Ensuring that the plan is achievable yet ambitious enough Ensuring complete transparency of budget management, activity and actions being taken to address under performance Ensuring section 75 agreements are clear and explicit about local commissioning control Ensuring that the governance structure for the delivery of the programme of work is robust and well understood Ensuring that all parties understand financial environment, required system savings and willingness to work together to achieve this end result whilst also focusing on quality and patient outcomes Ensuring that patients are involved in shaping the pathway transformation Ensuring that patient feedback is captured throughout the delivery of the programme

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Guildford & Waverley CCG

Scheme ref no.
GW1
Scheme name
Primary Care Plus
What is the strategic objective of this scheme?
Support the Frail Elderly population in the community
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated community and primary care
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP Practices **Virgincare PLC** **Surrey County Council**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £1.2m
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The local BCF architecture described above
What are the key success factors for implementation of this scheme?
Reduction in unplanned admissions

Scheme ref no.
GW2
Scheme name
Rapid Response
What is the strategic objective of this scheme?
Improve facilitated discharge
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Provide integrated care packages that support people on discharge.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP practices **Royal Surrey County Hospital** **Virgincare PLC** **Surrey County Council**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £6m
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Local BCF architecture described above
What are the key success factors for implementation of this scheme?
Reduction in length of stay

Scheme ref no.
GW3
Scheme name
Telecare
What is the strategic objective of this scheme?
To support people to remain independently living in their own homes
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Providing telecare solutions as a component of joint health and social care planning.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP practices **Virgincare PLC** **Surrey County Council**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £608k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The local BCF architecture as described above
What are the key success factors for implementation of this scheme?
Reduced hospital admission and reductions in residential care spend

Scheme ref no.
GW4
Scheme name
Virtual Wards
What is the strategic objective of this scheme?
To prioritise those with high risk of hospital admission
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Community Matron workforce working together in GP practices to priortise interventions to an identified cohort of patients.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP practices **Virgincare PLC** **Surrey County Council** **Surrey and Borders Partnership NHS Trust**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £548k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The local BCF architecture as described above.
What are the key success factors for implementation of this scheme?
Reductions in emergency admissions

9

Scheme ref no.
GW5
Scheme name
Social Care/Reablement/Carers
What is the strategic objective of this scheme?
Supporting people to remain independently living in their own homes
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP practices **Virgincare PLC** **Surrey County Council**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £1.816m
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Local BCF architecture as described above.
What are the key success factors for implementation of this scheme?
Reduced spend in residential care

Scheme ref no.
GW6
Scheme name
Mental Health
What is the strategic objective of this scheme?
The provision of virtual wards for people with dementia
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Teams providing wrap around support to an identified cohort of people with dementia
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
21 GP Practices **Surrey and Borders Partnership NHS Trust** **Surrey County Council**
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated Care models elsewhere **Local Pilots** **QIPP evidence centre**
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £423k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Ongoing sustained level of independence and recovery for people with long term health and care needs • More individuals have their health and social care needs met in the most appropriate setting • Increased proportion of people with complex and long term health and social care needs receiving planned and coordinated care in, or close to home • Outcome: Improved satisfaction with health and social care services • Outcome: More individuals with dementia have a prompt diagnosis and proactive care planning is in place
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The local BCF architecture as described above
What are the key success factors for implementation of this scheme?
Reduced acute hospital admissions

North East Hampshire & Farnham CCG

Scheme ref no.
NEHF 1
Scheme name
Co-Commissioning Care at Home including NHS Continuing Healthcare and Funded Nursing Care
What is the strategic objective of this scheme?
To drive a more holistic management approach to Care at Home (Domiciliary Care) and Care Home (CHC and FNC) activity and spend to improve the quality and value for money of care underpinned by outcome driven incentives and appropriate needs based placements. In the short to medium term it is anticipated that through more effective market management, the joint utilisation of a single outcome based provider framework across Health and Social Care and review of "access points to service" and eligibility, spend can be reduced for Care at Home and for Care Home CHC/FNC. Longer term opportunities relate to optimising the collective commissioning influence of Health and Social Care to shape the market to improve quality and value for money from providers. This work will align to the transformation of care pathways, including reviewing trigger points to service access, a greater emphasis on preventative care and the better use of technology to manage and monitor long term conditions.
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
In developing the BCF programme CCGs and HCC have drawn on the expertise and resource of Deloitte to provide an independent, external assessment of opportunities. Specifically this has been used to establish what savings can realistically be identified in 2015/16 as a further contribution to the resource available to secure social care services alongside exploring efficiencies in social care itself. An initial high level opportunity assessment identified a potential range. Although the assessment concluded that the top of the range should be achievable, it was agreed that a detailed analysis was needed to confirm the realistic range to inform a more robust savings target in this important opportunity area. The results of this work were presented to partners in July 2014. The assessment identified the following components of work: Market management – short term and longer term including the targeted use of outcome focussed framework contracts; Commissioning processes and controls; Integrated Commissioning Team – longer term The work streams have been divided in to two areas initially: Market Management and Commissioning Processes for Care at home Market Management and Commissioning Processes for Nursing Home settings. A detailed work programme is now being developed and will initially focus on opportunities for older people across Hampshire. NEHF CCG would like to work with Surrey County Council to align its work across the CCG locality.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Care at Home Framework in Hampshire identifies NEHF CCG as a potential participant. Detailed requirements will be added to mini – competition stage expected to involve circa 30

providers of which we will appoint 10 – 17 providers as prime contractors, being one per geographic lot with no provider having more than two lots
Integrated commissioning – optimising collective power/joint approach.
Analysing the market drivers and the incentives built into the market and highlight any saving opportunities that this presents.
Identifying opportunities to streamline transfer/access points into CHC pathways (e.g. end of life care) and standardise CHC pathways to reduce length of stay and market rates.
Developing proposals to establish joint commissioning teams to drive greater efficiency, a single point of accountability of assessment, improved patient experience and consistent and coherent practice across all CCGs.
Establishing proposals to optimise collective power/joint approach.
Ensuring that the remit of Integrated Care Teams (ICTs) is factored in and aligned with the whole pathway.
Identify ways to harvest related savings.
Manage the implementation of the agreed CHC and FNC proposals to ensure savings and improvements accrue during 2015/16.
Provide proposals for decision and implementation progress updates to the PMO at the key stage points in the BCF programme timescales (see separate doc) as well as monthly highlight report updates.
NEHF CCGs could then benefit from countywide rate, electronic care monitoring, automated payment and outcome focussed performance regime

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Care at Home
A detailed benchmarking exercise has been completed on a sample of 17 care at home providers across Hampshire, which has identified a significant variance in hourly rates and contractual terms. This benchmarking has shaped an opportunity analysis assuming a standard negotiated base rate, including outcome based performance payments to incentivise positive outcomes.

Funded Nursing Care
Benchmarking of Funded Nursing spend in each CCG area has been performed against regional and national ranges. This has identified a variation in levels of average spend which given the nationally set tariffs, are likely to be caused by eligibility controls and points of access.

Care Home NHS Continuing Healthcare
Analysis has been performed on fast track packages which limit the ability of CCGs to control activity and expenditure. This identifies a higher than regional average of fast track packages.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Limited additional investment beyond initial project costs will be required to deliver the market management savings.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Improved outcomes for people
Opportunity to drive improvements in quality and standardise care costs including joint procurement
Opportunity to streamline transfer or access points into CHC pathways to generate improved

patient experience Opportunity to streamline hospital discharge to CHC pathways e.g. EOLC Opportunity to integrate CHC and non-CHC delivery across agencies **Reduced service demand** Potential to standardise CHC pathways to reduce length of stay and delayed discharge. Opportunity to optimise collective power and scarce resources across CCGs and HCC including strengthening joint commissioning longer term **Reduced system costs** Significant opportunity to more effectively manage care costs through a single integrated commissioning framework between health and social care.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Electronic care monitoring, automated payment and outcome focussed performance regime
What are the key success factors for implementation of this scheme?
CCGs being able to identify and extract detail of current activity from existing data Terms of engagement Joint commissioning

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Scheme ref no.
NEHF 2
Scheme name
Telecare/Telehealth
What is the strategic objective of this scheme?
To utilise technology more effectively as part of an integrated out of hospital care plan to monitor and manage conditions better for both health and social care clients, enabling clients to retain their independence and remain out of residential care for longer. Through the effective implementation of both Telecare and Telehealth, the volume of face to face consultations for routine monitoring will be reduced and targeted monitoring of known at risk groups (e.g. those at risk of falls) can be more comprehensively monitored and responded to more effectively. It is estimated that approximately £0.5m of recurring efficiencies can be delivered through this programme.
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The current programme is based on a partnership approach and delivered locally by the Districts and Boroughs. Referrals come from a variety of sources including social care, health and self-referrals. Commissioners: Surrey County Council via Whole Systems Fund Providers: Currently District and Boroughs provide the service under a partnership agreement
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The evidence base remains mixed as it is impossible to isolate the effect of Telecare from other interventions. Local case studies indicate that Telecare enables people to feel safe , independent and reassured that they can access help quickly at times of crisis. Reports from social care practice show Telecare is often used to help meet a client's needs where otherwise more expensive services may be required In summary the use of Telecare has the potential to make a significant contribution to the prevention agenda by directing care where it is needed and potentially reducing the need for more costly levels of intervention. Discussions have begun that will establish the extent to which deployment of telecare by clinicians for patients at risk of falls can deliver benefits such as emergency admission reduction. Work is commencing to understand what telehealth solutions are in use across the county currently and what benefits are being achieved and recorded. Initial discussions have taken place with Argenti to assess the scope for deploying telecare for fallers and opportunities to get existing telehealth equipment into active use. Proposals to

develop a telehealth pilot with Frimley Park Hospital focusing on supported self management for people with respiratory problems are currently underway.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Business cases are under development

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Improved Outcomes for People

- people are supported to remain independent in their own homes
- Increased awareness, client independence and self management;
- Reduced anxiety

Reduced service demand

- Can reduce the impact of falls, hospital admissions, A&E attendances and length of stay
- Fewer ambulance call-outs (assumed 1 less call out per annum for high risk clients);
- Reduced urgent care attendances and admissions with associated diagnostics;
- Earlier discharge;
- Fewer avoidable face to face consultations.

Reduced system costs
System cost reductions mostly relate to avoiding high cost incidents (e.g. Ambulance call outs, A&E admissions, MAU admission

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

1/4ly performance reporting
1/4ly meetings with providers
Regular feedback from social care teams about impact to service provided
Case studies
For 15/16 – redefine reporting to include impact of provision against outcomes

What are the key success factors for implementation of this scheme?

Significant interdependency with the redesign of care pathways through the effective roll out of integrated care teams.
Changing attitude and behaviour of referring staff once people are identified.
Joint commissioning.

Scheme ref no.
NEHF 3
Scheme name
Reablement/Rehabilitation
What is the strategic objective of this scheme?
To reduce the risks of intensive cost of care at home, long term residential care or re-admittance through more effective and integrated reablement provision. This aims to strengthen focussed and targeted rehabilitation in the community, enabling patients to regain their functional and daily living skills more quickly and remain more independent in their own homes with appropriate support.
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme information should be read alongside the Discharge to Assess scheme. Reablement style services have been established in both Hampshire and Surrey for some time. In Hampshire, the model has been further refined in the last year to procure and mobilise a service in partnership with the domiciliary care market. The current service offer comprises Community Response Team, Sensory Services and Independent Domiciliary Care Providers. The financial framework for this new service model is expected to deliver savings on longer term domiciliary care interventions throughout the life of the contract. Efficient use of contracting by CCGs and SCC to reduce hospital admissions. In Surrey, there is a proposal to undertake a similar programme of work at a county-wide level. This will include: • Stop agreeing fee exceptions • Incentivise care homes to work with GP clinical networks to prevent acute admission • Merge Surrey health and social care market management and administrative functions for residential, nursing and domiciliary care • Indicate to the market that Surrey would like to reduce the volume of residential care and expand extra care; look at how local health and social care economy interfaces eg weekly clinic in extra care setting to promote admission avoidance • Use existing contracts more effectively to reduce admissions ie to improve contract compliance whilst residents are in hospital Work with Public Health to ensure: • Adequate robust health protection policies are in place and implemented in all nursing homes to prevent and adequately manage outbreaks such as norovirus. • All residents have adequate nutrition and hydration to prevent UTIs **Progress to Date** **Scoping** Somerset Care delivers the service across Hart and Rushmoor. They have delivered 325 hours of service which is equivalent to 38% of contract volume and this is because staff recruitment in this area is very challenging. HCC are monitoring the delivery of the service very closely in this area to ensure its growth and capacity to deliver to contract volume. A reablement ethos is being embedded in NEHF CCG in the local Out of Hospital Care model. Pilot using winter pressures 13/14 to use OT expertise to in reach and identify people suitable for reablement option. Outcome being used to inform further development

Developing model aligned with Discharge To Assess in strategic hubs across the county. Currently 4 reablement beds in Ticehurst. Jointly considering strategic hub in Ticehurst with investment from health to increase the bed capacity to 10 beds.
The delivery chain **Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved**
All CCGs and HCC commissioners Primary Care Providers Community Providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence derived from detailed market analysis across Hampshire population undertaken in 2013
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan As per spreadsheet
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Existing investment. **Improved outcomes for people:** Improved health, wellbeing & quality of life for people in NE Hampshire and Farnham as people become reabled and supported towards independence. Improved satisfaction with health & social care services. Increased proportion of people with complex & long-term health/social care needs receiving planned & coordinated care in, or close to, home through the ongoing assessment and review carried out by this service and the right sizing of care packages to meet their needs Improved capability, choice & control for people to manage their own health & wellbeing as people are supported to be more resilient and better able to cope with their needs. Reduced difference between those with the best & worst health. Right care delivered seamlessly in right location and time through better co-ordination Restoring people's ability to perform usual activities and improving their perceived quality of life. **Reduced service demand** Increased proportion of people benefitting from evidence based prevention & early intervention. This will be clearly evidenced via assessment and reviews undertaken as part of the service. Increased self-sufficiency & independence as people are reabled. Reduced dependency & reliance on publically funded services as the service connects people to local voluntary sector organisations as appropriate which will in turn delay peoples' dependency on long term health & social care interventions and aid improved & speedier recovery for people. This will assist in avoiding unnecessary cost in the system, moving to lower cost solutions. Reduction in emergency admissions (local target TBC) Reducing or removing the need for ongoing support via traditional home care - reduce the

number of care hours required to support a person at home or to develop their independence so that they can remain in their own home instead of being admitted to residential or nursing care.

Reduced system costs

Effective reablement will contribute to reduced system costs through avoiding or delaying high cost spend in residential, nursing, community or acute sector beds.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Electronic care monitoring, automated payment and outcome focussed performance regime, BCF Metrics

What are the key success factors for implementation of this scheme?

Alignment with our out of hospital care service model
Workforce transformation required to adopt efficient processes
Provision of equipment in the home settings for people with limited mobility, safety and security issues
Availability of community health and primary care services to support more intense needs
Domiciliary care capacity and capability
Occupational therapy skills

9

Scheme ref no.
NEHF 4
Scheme name
Discharge to Assess
What is the strategic objective of this scheme?
To improve the effectiveness of the discharge and assessment system and process, as part of the overall redesign of a joined up and integrated care pathway in Hampshire. It is expected that this workstream can deliver savings by reducing discharge bed days and reducing re-admittance rates through improving the effectiveness of joined up hospital discharge and assessment.
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme information should be read alongside the reablement scheme above. Further local detail is available on request. Overall description: Developing the principles of a D2A process that will establish trusted assessment, integrated health and social care delivery, enhanced access to rapid assessment and diagnostics, enhanced recovery and support at home and universal admission criteria. Developing proposals to implement the out of hospital care models in each system which includes an approach for how savings will be harvested. Making recommendations around an implementation plan for the new process and how staff will be engaged to ensure that the new process is embedded. Ensuring strong links with Integrated Care Teams to ensure discharge support whilst the person is awaiting full assessment. Manage the implementation of the agreed discharge to assess proposals to ensure savings and improvements accrue during 2015/16. Provide proposals for decision and implementation progress updates to the PMO at the key stage points in the BCF programme timescales as well as monthly highlight report updates
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Whole Hampshire workshops involving national expert input Concept piloted in 2013/14 to inform design work Further scoping meeting involving all partners and local providers Local mapping event took place on 19 September 2014 Discharge to Assess Steering group established
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence derived from national work Warwickshire and Cambridgeshire supported by national ECIST team
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Improved outcomes for people Reduction in the number of people entering long term residential or nursing care Improved patient and carers experience (PROMS) Faster hospital discharge/ reduced number of hospital discharge delays Minimise loss of confidence and decompensation Reduction in hospital mortality Decreased in admission to permanent residential care Less patient ward moves e.g. into escalation beds **Reduced service demand** Reduction in Delayed Transfers of Care Reduction in avoidable admissions, with more people supported at home Reduction in community bed based provision Reduction in acute excess bed days/ length of stay (post trim point) Improved hospital flow/ reduction in delayed transfer of care Reduction in new CHC packages due to fewer patients requiring packages of care or requiring less costly packages of care **Reduced system costs** Significant medium term efficiencies to be released through positively impacting on the demand metrics outlined above (e.g. delayed transfers, reduction in length of stay etc.). Work is planned to develop a benefits realisation programme to measure the impact of system cost.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
BCF Metrics including DTOC, care requirements, 7 day working overall system performance, experience of people using services
What are the key success factors for implementation of this scheme?
CCG being able to work towards alternative payment mechanisms Full engagement with providers when incentives and levers may not be the same Joint commissioning Strong link with reablement work stream Requires 100% Discharge to Assess occupancy

Scheme ref no.
NEHF 5
Scheme name
Reviewing Historic Partnership Funding
What is the strategic objective of this scheme?
To review all jointly funded schemes to maximise the alignment of spend to deliver the strategic objectives of the BCF and integrated out of hospital care model
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
As part of the programme of work to produce the draft BCF submission in February 2014, analysis was undertaken to establish greater transparency on where resources were deployed and the benefits of doing so. The outcome of this analysis was then used in the financial framework for the BCF. An agreed summary of all Section 256 agreements was compiled, incorporating summary description of schemes and financial breakdown (including health contribution and HCC spend against each scheme) across Hampshire and Surrey. As part of the transition to the BCF approach, all schemes rolled forward to 2014-15. This initial review provides the basis of a further programme of work to identify cashable efficiencies in 2015/16. A Hampshire county-wide Section 256 Steering Group has been established and will review all Section 256 agreements to agree scope of review and priority areas which afford maximum opportunity to derive efficiency savings.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Further detailed work to identify opportunities to make savings through the reduction in duplication or lower benefit grants and develop proposal for a realignment of spend. Developing options and making recommendations for the future allocation of this funding. This will inform decision around future requirements and any contractual changes required. Manage the implementation of the agreed section 256 agreement proposals to ensure savings and improvements accrue during 2015/16.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Detailed analysis of existing spend undertaken to establish greater transparency on where resources were deployed and the benefits of doing so.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Existing investment
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in

headline metrics below
Improved outcomes for people Reduced difference between those with the best & worst health; Right care delivered seamlessly in right location and time through better co-ordination; Targeting spend on projects delivering the key objectives of the BCF. **Reduced service demand** Reduced dependency & reliance on publically funded services; Targeting resources more effectively to focus on key performance objectives of BCF. **Reduced system costs** Reduced duplication of health and social care spend; Re-prioritisation of spend to align with meeting BCF outcomes.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
On-going monitoring of BCF performance metrics. Value for money reviews of existing spend.
What are the key success factors for implementation of this scheme?
Digital and IT work stream Market management System resilience

9

Scheme ref no.
NEHF 6
Scheme name
Integrated Provider Delivery Model
What is the strategic objective of this scheme?
To drive an integrated model of provision across community health and local authority adult social care services in collaboration with the emerging GP Alliances across NE Hampshire and Surrey. This will avoid unnecessary duplication in the care pathway (e.g. duplicate assessments / visits) and maximise the benefits of a person centred integrated workforce, including information sharing, co-location, single assessment process and strengthened clinical leadership In the short to medium term it is anticipated that through more effective integrated team working and joint management, the experience of the public will be even more "joined up" Longer term opportunities relate to co-producing the optimal local model underpinned by collective commissioning to shape the market to improve quality and value for money from providers.
Overview of Scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
In developing the BCF programme NEH&F CCG have drawn on the expertise and resource of Deloitte to provide an independent, external assessment of opportunities (working with Hampshire County Council). An initial high level opportunity assessment identified a potential range of benefits and the opportunity to enhance these by aligning local integrated delivery with GP alliance models that will serve to strengthen the response through better information sharing and stronger links to the domiciliary care market in the CCG's locality. This transformation work stream will relate to the deployment of this resource in a model where better care costs less. The approach will accelerate:- • Integrated delivery through 5 Integrated Care Teams (4 in NE Hampshire and 1 in Farnham) • Workforce transformation in both the community provider and adult social care • Estate and Asset utilisation through co-location • Back office and support functions to reduce infrastructure costs A detailed work programme is now being developed and will initially focus on opportunities for older people. This will: • Capture evidence of capacity of 'as is' view of skills across multidisciplinary teams. • Identify opportunities for different workforce arrangements/teams to make savings and improve effectiveness of the combined resources from each partner. • Develop proposals to deliver training and skill sharing plan across teams to reduce time spent on non value-adding tasks enhancing efficiency and improving the service delivered. • Manage the implementation of the agreed workforce efficiencies proposals to ensure savings and improvements accrue during 2015/16 The outcome of this approach will strengthen delivery of integrated care. It will align the provider development with the ambitions of the BCF, in particular establishing sustainable local services as well as the opportunity to realise delivery of key programmes of the BCF plan including:- discharge to assess and rehabilitation/reablement programme and potentially further integration of telecare and telehealth in the local integrated care team

offer. Plus CHC and FNC aligned and embedded with the work of Integrated Care Teams
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
NEHF CCG is a potential participant as a co-commissioners of primary care Southern Health NHS Foundation Trust. Integrated commissioning – optimising collective power/joint approach. Analysing the market drivers and the incentives built into the market and highlight any saving opportunities that this presents. Embedding opportunities to streamline transfer/access points into care pathways (e.g. end of life care) and standardise pathways to reduce length of stay and market rates e.g. NHS CHC. Developing proposals to establish joint commissioning teams to drive greater efficiency, a single point of accountability of assessment, improved patient experience and consistent and coherent practice across all CCGs. Establishing proposals to optimise collective power/joint approach. Ensuring that the remit of Integrated Care Teams (ICTs) is factored in and aligned with the whole pathway. Identify ways to harvest related savings. Manage the implementation of the agreed CHC and FNC proposals to ensure savings and improvements accrue during 2015/16. Provide proposals for decision and implementation progress updates to the PMO at the key stage points in the BCF programme timescales as well as monthly highlight report updates. As a CCG we could then benefit from countywide rate, electronic care monitoring, automated payment and outcome focussed performance regime
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Best practice examples of integrated care teams including Outer North East London, North West London, Torbay, Greenwich etc. National LTC programme evidence Kings Fund, Nuffield Trust and Health Foundation academic studies National Voices integration “I” statements
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Limited additional investment beyond initial project costs will be required to deliver. Working with Health Education Wessex to identify education commissioning impact
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Improved Outcomes for People Commissioning opportunity to drive improvements in quality and standardise care costs taking advantage of jointly commissioned care at home Opportunity to streamline transfer or access points to improve experience Opportunity to integrate care and support of people with most complex needs and delivery across agencies More effective integrated assessment and person (rather than organisation) centred care Re-ablement, ablement and independence achieved with fewer contacts

Reduced service demand Potential to standardise care pathways to reduce length of stay and delayed discharge through more reliable in-reach. Opportunity to optimise collective power and scarce resources across CCGs and HCC including strengthening joint commissioning longer term Increased demand will be met by re-engineering how the service is delivered **Reduced system costs** More effectively realise benefits by managing care and support costs through a single integrated commissioning framework between health and social care. Avoid cost of duplication and system fragmentation Economies of scale – shared infrastructure, investment and management costs.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Electronic care monitoring, automated payment and outcome focussed performance regime Clinical activity monitoring BCF metrics Patient experience and workforce feedback
What are the key success factors for implementation of this scheme?
Financial modelling of impact Modelling of benefits in terms of service quality to ensure no deterioration Education Commissioning capability Bespoke development e.g. telecare Communications / consultation with workforce and public about what to expect Joint commissioning CCGs being able to identify and extract detail of current activity from existing data Terms of engagement between Southern health NHS Foundation Trust and Adult Services

9

Scheme ref no.
NEHF 7
Scheme name:
Primary Care Development
What is the strategic objective of this scheme?
Implementation of Integrated Care Teams, risk stratification, proactive case management and coordination, information sharing, co-location, single assessment process and strengthened clinical leadership
Overview of the scheme
Implementation of Integrated Care Teams • Piloting integration in one GP locality (go live in October 2014). Wider roll out completed across CCG by March 2015. • Action plans will be agreed for each locality to track progress; • Transforming Primary Care workshop took place in with Primary Care and Community Services to discuss issues with community services provision and to start planning work relating to the integration BCF; GP forum in October to progress co-commissioning arrangements/implementation of integration and BCF workstreams. • IT GP lead working with pilot locality to scope remit for data sharing requirements between **Risk stratification** • All Practices signed up to admission avoidance DES. Internal meeting took place to discuss how the CCG will support support identification of 2% at risk population, dual care planning process; • CCT to review current caseload and map data working with GP practices to identify top 2% • Adult Social Care are identifying top 2% of social care service users for cross referencing with health at risk population; Telecare/Telehealth • Workstream developed to review and map current telecare/telehealth inteventions across CCG locality. • Development of business case to expand use of telecare/telehealth supporting top 2%.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved:
North East Hampshire and Farnham Clinical Commissioning Group Surrey County Council Primary Care Frimley Park Hospital and Royal Surrey Southern Health Virgin Care Solent Care Surrey and Borders Partnership Voluntary and Third Sector organisations
The evidence base Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme - to drive assumptions about impact and outcomes
There is a plethora of emerging evidence supporting the need to provide locally joined up, health and care services for our local communities.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan Business plan currently under development.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Oversight and monitoring of BCF and integration projects will be provided by NEHF CCGs Local Joint Integrated Commissioning Group.
What are the key success factors for implementation of this scheme?

9

North West CCG

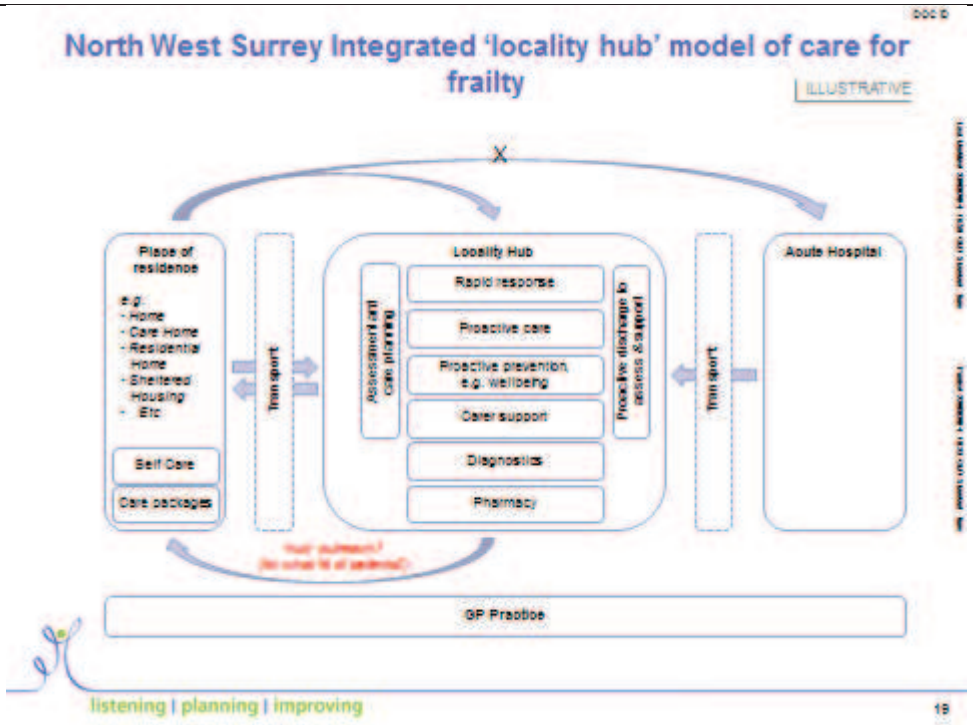
Scheme ref no.
North West Surrey BCF Scheme 1
Scheme name
Integrated Health and Social Care "Locality Hubs"
What is the strategic objective of this scheme?
NW Surrey Strategic objective: *"We will have a vibrant, dynamic, integrated network of enhanced care services where patients will have an accountable physician and a multi-disciplinary care delivery team, delivering preventative and responsive treatment. Supporting both pre-frail and frail cohorts to live at home, healthily, safely and happily for as long as possible."* Our ambition is to keep people healthier at home for longer; no one will be in an acute bed because they are frail. We believe that integrating services around the individual and taking a proactive, holistic approach will enable us to optimise care, and the resources already available in the system. By actively identifying and seeing people regularly according to risk rather than defined clinical need we will be able to prevent the 'sudden health status changes' that so often lead to hospital attendance, long stays in the acute sector, deterioration in underlying health and independence, and ultimately admission to a care home. It is envisioned that three Locality Hubs will be established, a physical place where services coalesce to provide proactive care and support for frail people under physician leadership.This programme drives health and social care to work closer together and 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, living independently as long as possible; improving outcomes for North West Surrey residents.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model of Care Working with stakeholders across the health and social care system, including service users, carers,staff and third sector agencies we have defined the model of care in three elements: **1. Pre-frail pathway** This will focus on identifying and mobilising the individual's asset base, including friends, family and community resources. We will draw on existing service provision (for example via Wellness Centres, borough councils and the voluntary, faith and charitable sectors) to identify support services for people. We will ensure robust signposting and 'referral' is established via primary care and that regular follow up is built in to actively review people in this stream. **2. Integrated frail care** Building on learning from evidence-based national and international systems of good practice (for example ChenMed); we will establish one-stop-shop locality hubs in each of our three localities.

Subject to a series of design workshops with clinicians and professionals from across the system together with patient representatives, these hubs will provide, for example:

- Aligned out of hospital community, mental health and social care resources under the leadership of primary care physicians in one physical location to deliver a fully integrated proactive service for frail people.
- Process engineered systems to optimise patient care and flow, and maximise resource use, efficiency and effectiveness.
- Embedded case management and care navigation to ensure co-ordination across the whole system of care, with active in-reach to the acute setting when required.
- Visiting hospital specialists to ensure frail people get the majority of their healthcare needs met in the hub.
- Education and wellness services to help people remain independent, to support families and carers and to prevent avoidable deterioration.
- Social activities, statutory agency advice and voluntary sector services to ensure the wider needs of people, their families and carers are catered for.
- A single point of access for both medical and non-medical services for people in the defined cohort and their carers.
- Dedicated transport infrastructure.
- Extended 7-day access to primary care
- Embedded primary care physician cover in the out of hospital urgent care pathway (for example in Walk in Centres).
- Medicines management teams will form a part of the multi-disciplinary team at the locality hubs providing expert advice in relation to medicines

3. Responding to frail people on the urgent care pathway

The Integrated Care Programme focuses on the proactive care of frail people to keep them well and at home. There will always be times, however, when frail people require hospital-based acute care. Through the Locality Hubs we will ensure that there is active follow through of people who are receiving acute care.



Target Group

Whilst there is no single definition of frailty, from the evidence of Edmans et al, we know that focusing our effort on a defined group of people is critical to improve outcomes. Working with Public Health we conducted a needs analysis to propose the cohort we will target in the first phase of the programme.

Three potential cohorts were considered:

- Broad definition – principally all people over 85 plus those 75 and over who have long term conditions (c. 25,000 people)
- Diagnosed frailty– people 'diagnosed' as frail (c. 5,000 people)
- Frailty broad – people who reflect a number of age related, social and disease-specific factors (c. 10,000-15,000 people)

In order to maximise the impact of the programme it is proposed to adopt the 'Frailty broad' definition. The initial scope of the programme, therefore, includes:

- Residents registered with a North West Surrey CCG GP aged 75 years and older who have been 'defined' as 'frail' (either through assessment or a functional screening tool)
- People living in nursing homes and residential care homes in NWS
- People over 75 receiving a social care or CHC funded package of care
- People receiving a social care or CHC funded package of care
- People with dementia
- People diagnosed with Parkinson's disease
- People diagnosed with Multiple Sclerosis (MS)
- People in the last 12 months of life

This cohort was discussed and agreed through a series of workshops with health and social care colleagues during 2013/2014 and is being tested further tested via Locality Network Boards (chaired by local GPs) Clinical Reference Groups and patient participation groups during 2014/15.

We will ensure proactive screening in primary care to anticipate frailty, and to identify and activate the individual's asset base.

It is proposed to apply the Edmonton Frail Scale, an evidence based functional assessment tool, to identify frailty in the targeted population. In 2015/16 we will incentivise primary care to review all of the people over 75 on their list. In the meantime we have asked practices to apply the scale to the 2% of highest risk patients they are currently identifying as part of the Admissions Avoidance Directed Enhanced Service (DES). Frail patients will then be identifiable via a Read code in the primary care record.

The CCG has invested in the SOLLIS risk stratification tool to enable practices to identify their top 2%, which, under the terms of the DES, they are required to renew quarterly. In the future we will develop the use of this tool to enable more sophisticated identification of the frail and pre-frail population.

We will agree via the project group and test with the Network Boards and Clinical Reference Group what score on the frailty scale will define a person as 'frail' or 'pre-frail' for the purposes of our work; both populations will be identifiable in the record and targeted through this programme.

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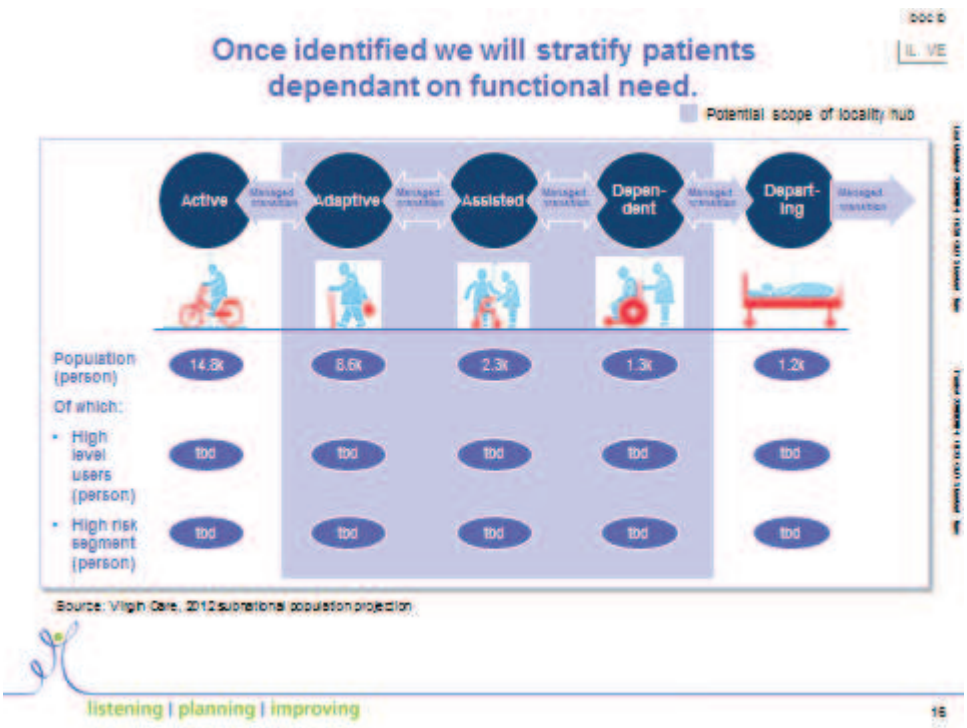
The project will identify other settings in which frailty might be 'diagnosed', for example via social care or A&E.



The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The outcome of this approach will strengthen delivery of integrated care. It will align the provider development with the ambitions of the BCF, in particular establishing sustainable local services as well as the opportunity to realise delivery of key programmes of the BCF plan including:-

- Promoting and maintaining healthy and independent living
- Developing early and proactive support in order to prevent health and social deterioration
- Empowering people with long-term conditions to live well, offering proactive, planned support to those with more complex needs
- Planned access to services in order to avoid emergency admissions
- Working in partnership with acute providers to deliver person-centred acute care
- Provide a discharge to assess model working with integrated community teams to return patients home once medically stable to enable assessments of need outside of an acute hospital
- Rehabilitation, reablement, therapies, community nursing and social work will be commissioned through a joint approach and delivered through one MDT.
- CHC and FNC aligned and embedded with the work of Integrated Care Teams
- Identify opportunities for different workforce arrangements/teams to make efficiencies and improve effectiveness of the combined resources from each partner.
- Develop proposals to deliver workforce sharing across teams to reduce time spent on non-value-adding tasks enhancing efficiency and improving the service delivered, such as the trusted assessor model.

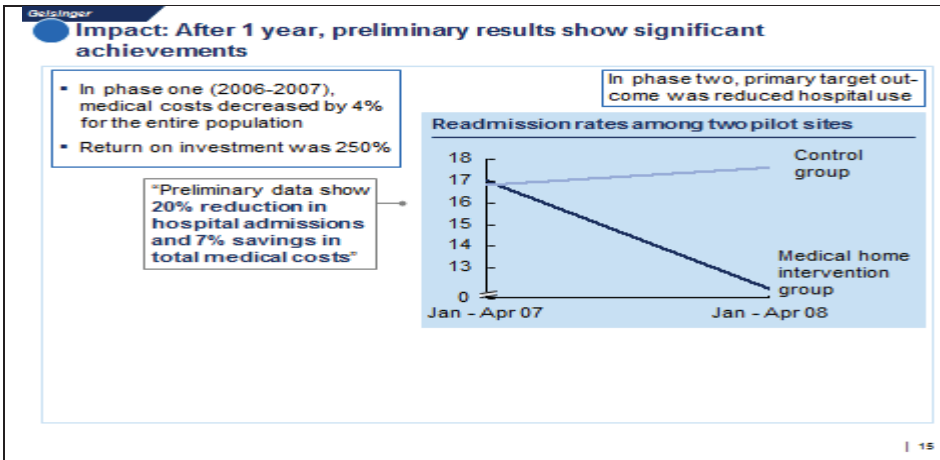
The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Locality Hub model of care has been based on community, physician led, US delivery of care models and adapted to the NW Surrey population.

- Geisinger USA Models of Care



- Chen Med USA Model of Care

18% lower hospitalisation rates, 17% lower readmissions, 22% lower cholesterol levels for patients on statins, 38% reduction in hospital days,
100% increase in patient experience scores.
Best practice examples of UK integrated care teams North West London, Torbay

- National LTC programme evidence
- Kings Fund, Nuffield Trust and Health Foundation academic studies
- National Voices integration "I" statements Oliver et al, 2014

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

See Spreadsheet.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The BCF drives achievement and collaborative working regarding a number of key metrics; such as reducing emergency admissions, delayed discharges and admissions to nursing and residential homes.

This programme will work with stakeholders, including frail people, their families and carers, voluntary and patient representative organisations and health and social care agencies to establish the outcomes and identify the metrics that will define a good and effective service.(Linking to BCF Programme 2)

We will establish payment mechanisms to reflect the characteristics of this particular group – for example adopting a 'year of care' model. We will also work to establish integrated billing, for example via an Alliance Contract model or application of a Prime Provider model.

Over time the CCG will build this into a contractual mechanism that enables capitation outcomes based commissioning and procurement of an end-to-end frailty service.

Improved outcomes for people

- Empower people to co-produce their own care plans
- People will receive a more joined up and responsive service
- Reduce people's experience of fragmented care provision
- Enabling people to live healthy and independently for longer
- Reduce people requiring acute crisis support
- Increasing people's access to planned, proactive care when needed

Improved commissioning benefits

- Commissioning opportunity to drive improvements in quality and standardise care costs taking advantage of jointly commissioned care at home
- Opportunity to streamline transfer or access points to improve experience
- Opportunity to integrate care and support of people with most complex needs and delivery across agencies
- More effective integrated assessment and person (rather than organisation) centred care;
- Re-ablement, ablement and independence achieved with fewer contacts.

Reduced service demand

- Potential to standardise care pathways to reduce length of stay and delayed discharge through discharge to assess.
- Opportunity to optimise collective resources across CCGs and SCC including strengthening joint commissioning longer term
- Increased demand will be met by re-designing how the service is delivered
- Reduced acute emergency care through planned access to services

Reduced system costs

- More effectively realise benefits by managing care and support costs through a single integrated commissioning framework between health and social care.
- Avoid cost of duplication and system fragmentation
- Economies of scale – shared infrastructure, investment and management costs
- Ensure providers demonstrate value for money and are commissioned at the right price

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Network Boards
Clinical activity monitoring
BCF metrics
Patient experience and workforce feedback
Local Joint Commissioning Group

What are the key success factors for implementation of this scheme?

Financial modelling of impact
Modelling of benefits in terms of service quality
Local Network Boards established, led by local GPs and providing leadership
Identification of suitable premises
Communications / consultation with workforce and public about what to expect
Joint commissioning
Integrated patient record and patient activity tracker

Risk and Mitigating Actions

Risk: Localities do not engage with the concept and principle of Locality Hubs
Mitigation: Localities are already agreed in principle to the concept, continuing engagement and actually getting started with the programme will add confidence to delivery and allow localities to further refine the concept.

Risk: A conflict of interest arises between GPs as commissioners and GPs as providers.
Mitigation: Separate provider and commissioning roles and role-holders as far as possible. Ensure clarity of actions to prevent and identify conflicts of interest.

Risk: Delay arises to the delivery of the outcomes Mitigation: Identify resource requirements in the Programme Initiation Document. Risk: Partners do not engage with the concept of locality-delivered care Mitigation: Very significant co-design and engagement is in process to ensure all views are represented and partners feel able to support the proposal. Risk: Partners are unable to make required interface or delivery changes due to resource constraints, or other factors Mitigation: Early engagement and co-design and planning.

9

Scheme ref no.
North West Surrey BCF Scheme 2
Scheme name
"Mission 90"
What is the strategic objective of this scheme?
Strategic objective: In five years, the average age of a state funded older person being admitted to a Nursing Home will be 90 years old. (Baseline Average age of admission to residential home 87 years and Nursing Homes 85 years (2014) By supporting the older people of Surrey healthier and happier, improving current healthy life expectancy of 76 years old By enabling people over 75 years old to live independently for one more year on average in the last ten years of their life.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Mission 90 aims to enable people over 75 to stay healthy and independent at home for one year longer; through effective use of resources and integration of the commissioning process and consolidation of the inputs and outputs from the voluntary sector • To develop an outcome based commissioning framework through co-design with older people of Surrey and voluntary sector stakeholders • Financially incentivise voluntary organisations to achieve defined outcomes for people over 75 years old, which supports them to live healthier and happier and independently for longer • To integrate current health and social care current spend on voluntary organisations servicing the adult population starting July 2015. • To jointly performance manage providers against commissioning framework
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Surrey County Council and NHS NW Surrey CCG through Local Joint Commissioning Groups
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Older people tend to suffer from a range of physical, mental and social conditions. Such as one or a combination of conditions below: • Loss of or weakened hearing and sight • Challenge with mobility • Challenge with cognition

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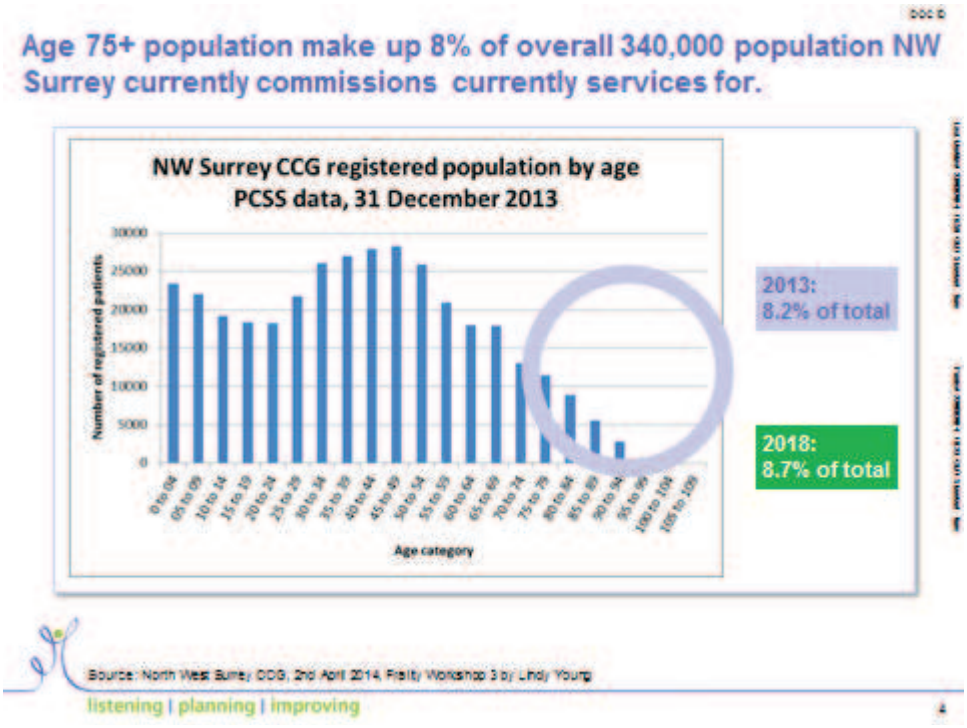
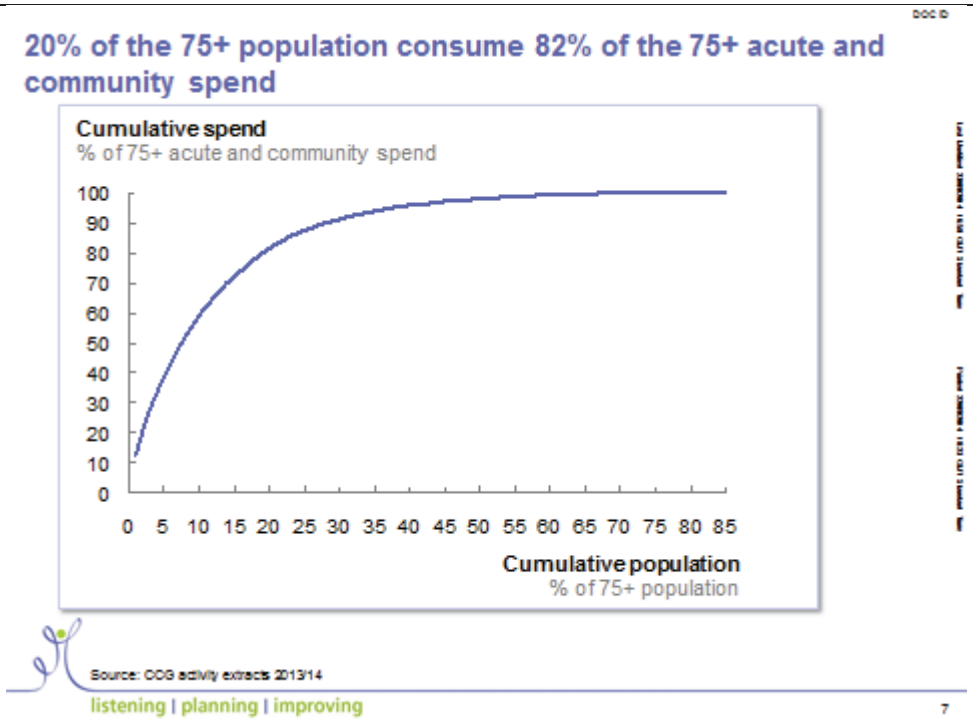
- Dementia
- Parkinson's disease
- Other long-term conditions
- Obesity, weight loss and malnutrition
- Potentially struggle with loneliness (Majority own their own home, and 1/3 of men and 2/3 of women live alone)
- Vulnerable to sudden health status changes triggered by minor events (e.g. infection or fall at home)
- Some are not safe to live alone and live in nursing homes or residential care homes
- Some are in the last 12 months of life
- Suffer from multidimensional loss of energy, physical ability, cognition and health





5,600 individuals consume the majority of healthare spending within the target group of over 75 year olds.High cost health and social care service utilisation occurs most frequently in the last 10 years of life in NW Surrey. Current healthy life expectancy in NW Surrey is 76 years old, life expectancy is 80-84 years old. Average age of a patient receiving Virtual ward services is 79 years old, average age of a patient admitted at ASPHFT is 79 years old and those in a rehabilitation bed is 82 years old. The average age of a person admitted to nursing home or residential home is 85 and 87 years respectively,

Robust integrated commissioning of such services will increase measurable quality of service provision; Potential to engage volunteer workforce linked to friends, family and community. Promote dementia friendly communities and to target volunteers from those over 70 years old.

Evidence:
Joint Surrey Health and Wellbeing Strategy
http://www.surreycc.gov.uk/__data/assets/pdf_file/0004/567382/UPDATED-health-and-wellbeing-strategy-doc.pdf

Health and social care needs assessment - Frail older people in NHS NW Surrey CCG (August 2014, Dr Eva van Velzen);

NHS North West Surrey CCG Rehabilitation and Reablement Review

NHS North West Surrey CCG Strategic Integrated Programme Delivery 2014

Windle, K Francis,J and Coomber, C (2011) Preventing loneliness and social isolation: interventions and outcomes, London: SCIE
Department of Health (DH) (2008) *Making a strategic shift towards prevention and early intervention: key messages for decision makers*, London: DH

Victor, C.R. et al. (2005) 'The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain', *Ageing and Society*, vol 25, no 3, pp 357−375.

Department for Work and Pensions (DWP) (2005) *Opportunity age: meeting the challenges of ageing in the 21st century*, London: DWP.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
SCC and CCGs Voluntary Orgs lines of spend
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reductions in admissions to nursing homes: Support the older population to achieve one more year of independent and healthy living as measured by the average age of admission to Nursing Homes and Residential Homes in Surrey. Baseline (2014) is 85 and 87 years respectively. Improvements in reablement success after 91 days Early identification and increase in dementia diagnosis Improvements in patient/citizen satisfaction
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Commissioning framework and performance of voluntary providers jointly managed through Local Joint Commissioning Group (LJCG)
What are the key success factors for implementation of this scheme?
User engagement Provider market
Timelines
By 01/04/15: Identify current lines of spend to include: Co-design / Consultation to define stakeholders and public Develop outcome commissioning framework Develop specification Develop Joint strategy Define monetary value (envelope) Market scoping / engagement Agree concordat conference Agreed outcome framework Surrey wide with locally defined delivery models and KPIs
Risks
Stakeholder engagement in defining and agreeing commissioning outcome indicators Agreement to consolidate SCC and NHS NW Surrey CCG funding Collaboration between voluntary sector providers to deliver jointly against the outcomes

Scheme ref no.
North West Surrey BCF Scheme 2a
Scheme name
Call for Back-up (C4B) Crisis response services "Insurance", promoting the non-statutory prevention market
What is the strategic objective of this scheme?
To promote well being and reduce anxiety for family and carers, which will result in decreased demands for health and social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Call for Back-up is a crisis response service linked to telecare that provides support from an appropriate agency to respond to a social care emergency or a non-injury fall. Different levels of interaction eg low level telephone befriending, health coaching, emergency response. To have senior review back up eg nurse/GP on Skype to aid decision making where needed.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Health and Social Care Commissioners Existing telecare provision by D&B Independent providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Pilot scheme undertaken in Surrey had good public engagement Similar schemes currently undertaken in UK
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Potential seed funding to be provided, but in-year recuperation to be agreed with provider
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduced ambulance call outs and Emergency department attendances

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Promotes people's well-being Reduces anxiety of people and family Diverts demand on health and social care system Carer support / resilience Decrease GP and health visitor contacts
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Number of Call for back-up contacts
What are the key success factors for implementation of this scheme?
• User engagement • Provider market
Risks
G – provider able and willing to interface with whole system G –user affordability G – potential provider market AMBER – potential challenge that this could contravene Health free at the point of care

9

Scheme ref no.
North West Surrey BCF Scheme 3
Scheme name
Joint Whole System Demand Management
What is the strategic objective of this scheme?
To reduce non-elective admissions by effectively using health and social care commissioning levers. Particularly focusing on nursing, residential and home based care. This will interface with all the other BCF projects.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Demand management with incentives for admission avoidance • Current fee levels in ASC not attractive to market, thus risk future joint tender for nursing care will fail • Utilise acute spend via admission avoidance to incentivise care home providers to reduce admissions Efficient use of contracting by CCGs and SCC to reduce hospital admissions. • Stop agreeing fee exceptions • Incentivise care homes to work with GP clinical networks to prevent acute admission • Merge Surrey health and social care market management and administrative functions for residential, nursing and domiciliary care • Indicate to the market that Surrey would like to reduce the volume of residential care and expand extra care; look at how local health and social care economy interfaces eg weekly clinic in extra care setting to promote admission avoidance • Use existing contracts more effectively to reduce admissions ie to improve contract compliance whilst residents are in hospital Work with Public Health to ensure: • Adequate robust health protection policies are in place and implemented in all nursing homes to prevent and adequately manage outbreaks such as norovirus. • All residents have adequate nutrition and hydration to prevent UTIs
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Surrey Health and Social Care commissioners Health and Social Care procurement functions Domiciliary care providers Voluntary sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes

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• 6,700 non-elective admissions (including self-funders) across Surrey in 2011 from residential care and nursing homes • Current duplication in the contract monitoring process • Proposition of people in Surrey dying in hospital is higher than average • Excess bed days
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
None
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduce rate of admissions from each care home Reduce excess bed days Reduce hospital admissions Reduce ED attendances Reduce diagnostic requirements Increase the proportion of people dying in their preferred place Increase income Improve user/carer experience Reduce delayed transfers of care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Via aligned contract monitoring
What are the key success factors for implementation of this scheme?
Integration of health and social care commissioning Communication Coordinated contract Management
Risks
A – workforce and skill base investment G – market engagement with the updated principles G – increased admissions direct to nursing homes G – insufficient Extra Care to support the model
Milestones
October • Adjust nursing care tender for joint integrated commissioning • CGGs commissioning intentions • Plan incentivisation to residential/nursing homes from excess bed days savings December • Agree plan for administrative integration • CCGs provider contracts July • Nursing care tender for joint integrated commissioning go-live

Surrey Downs CCG

Scheme ref no.
SD **1/45 (Projects 30)**
Scheme name:
Primary Care Networks; Community Medical Teams
What is the strategic objective of this scheme?
To support discharge and prevent admissions and re admissions to the acute sector by providing an enhanced multi-disciplinary medical service across GP practices grouped around Local Health Economies.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

Community Medical Teams (CMT)

A CMT is a team of medical staff operating across practices and linking with community and acute providers to manage a cohort of patients who are at risk or chronically ill but can, with additional support, be cared for in the community. The team will deliver multiple benefits:

- **Preventing avoidable admissions**
  - Local audit suggest up to 46% of medical admissions are preventable). In 2013-14, there was estimated to be 1152 avoidable admissions
- **Preventing unnecessary readmissions to hospital**
  - Local readmission rates are c.17-25% per year, which means patients are likely to be readmitted unnecessarily to hospital
  - The majority of readmissions occur within 5 days of leaving hospital
- **Improving medication concordance rates to ensure patient medication is reviewed upon discharge from hospital**
  - Among older patients (65+ years) 14% are discharged with medication discrepancies and have a higher risk of being readmitted to hospital within 30 days (Coleman et al 2005)
  - In 2008 NHS Surrey Medicines Management team undertook pharmacist led medication reviews in care home patients. Results from this piece of work locally found that 30% of the interventions (out of 708 reviews) were graded as significant which involved identifying the need to stop or start drugs to optimise therapy.*
- **Integrating services to provide a continuum of care across community**
  - The team will work across providers around the discharge pathway to improve co-ordination between all services who input in to discharging patients from hospital and ensuring patients go home safely
  - This team will attend multi-disciplinary meetings in acutes, community and GP practice settings. They will have a particular focus on complex patients with multiple co-morbidities spanning different services and ensuring social care and the voluntary are used effectively

A CMT will provide a continuum of integrated care for chronic disease management. The team will have multiple functions to include:

- medical case management in the community working with community services
- medical management of community beds
- interfaces within acute hospital Acute/Ambulatory Assessment Units for rapid diagnostics (day case only) to prevent admissions.

There is also the option to run a day hospital facility should the network be able to demonstrate there are gaps in local provision. Each CMT will have a GP Clinical Team Leader(s) supported by a team of GPs to provide medical management, assessments and prescribing. The Network will sub-contract with a consultant geriatrician/physician of their choice. Their role will include weekly

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ward rounds. These teams are new teams to be provided by the Networks around their local health economy I.E. local acute
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The CCG will commission this service from Primary Care Networks and work with local community providers and the voluntary sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
See above
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Plan 2015/16 £1,205,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribution to overall non-elective reduction of £2.6m for 2015/16.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The first outcome will be that the CMT's have been appropriately set up and are fully operational according to the specification. The specification is clear and describes all other performance and outcome measures.
What are the key success factors for implementation of this scheme?
Clear patient cohort to be scoped and functions to be defined. Integration across existing providers will be key as will re-designing existing resources to ensure collaboration with any new team or service operating at an intermediary level.

Scheme ref no.
SD 2/46 (Projects 14,26,29)
Scheme name
Improving the continuing care assessment process
What is the strategic objective of this scheme?
Ensure improved patient experience and outcomes within the continuing care assessment process
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• **Joint health and social care assessments, with inclusion of dementia and mental health providers in the assessment process** • **Streamline the healthcare assessment tool** and health needs assessment • **'Discharge to assess'**: purchase non-acute beds in care homes, including nursing homes for patients in Epsom, Kingston and SASH hospitals • **Pilot Local Authority Community Development Officers** in non-acute settings (e.g. community hospitals) • **Enable acute hospitals to undertake continuing healthcare placements**, capacity permitting, with support from the NHS continuing healthcare team • **Equipment** - Community, continuing care and disability grants: To review products held by the joint equipment store to improve the range of equipment, timely repatriation of products from homes and acute settings; achieving greater acuity of product selection.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Surrey Downs commissions and is the host provider for CHC on behalf of Surrey as a whole.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
CHC Service in Surrey was not operating in line with the CHC National Framework resulting in delays in the assessment of patients in continuing healthcare eligibility. As a result of this scheme the impact will be that the Surrey CHC process will be streamlined, efficient and qualitatively improved.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Plan 2015/16 £366,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
(see below)

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcome measures	Current Baseline (as at December 2013….)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Fast Track care package in place within 48 hours	0	To be added	To be added
% of continuing healthcare eligibility decisions within 28 days	60%	80%	95%
% of 3 month and 12 month reviews completed	8%	50%	95%
Improved service user/carer satisfaction (placement)	+	++	+++
Improved service user/carer satisfaction (assessment process)	Pilot Q commenced		
Number of formal complaints	48 What time period is this for?	10% reduction	20% reduction
Increase access to Personal Health Budgets for service users	NA	20	40
Reduction in DTOC (Delayed Transfers of Care)	To be added	To be added	To be added

What are the key success factors for implementation of this scheme?

The emphasis on improving the continuing care assessment process, discharge to assess, is anticipated to have the following impact:

- **Beds usage -** Higher throughput of patients with lower numbers of admissions and shorter lengths of stay in medical beds
- **Less readmissions** - Lower rates of unnecessary readmissions to hospital beds though these improved care packages that promote self-care and independent living
- **Multi-disciplinary teams** - Increased need for Consultants and Specialist Nurses to work as

part of multi-disciplinary teams, working into and within the community, to enable general practice and community teams to manage higher levels of medical acuity

- **Information** – Increased reliance on integrated information systems, assessments and knowledge of care packages before the patient arrives for medical treatment in assessment units
- **Costs** - Reduced revenue from longer stay medical admissions and length of stay (beds) but also reduced costs from fluctuating medical bed capacity, such as escalation wards dependent on bank staff.

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Scheme ref no.
SD 3/47 (Projects 8,10a,15,21,22,31,38)
Scheme name
An Improved and Integrated Discharge Pathway.
What is the strategic objective of this scheme?
To enable expedient/timely discharge for patients by ensuring that the full range of multi-agency services are available via a single point of access and streamlined assessment thus reducing length of stay and delayed discharges.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To redesign the access to community health, social care and voluntary sector services in the Surrey Downs locality. To co-develop and implement the discharge to assess model in Surrey Downs. The model of care and support is reliant on the discharge pathway being able to dovetail into the integration of community health, social work and reablement teams, as without these schemes the discharge pathway cannot be implemented. The patient cohort, in the first instance, will be those on the G.P preventing avoidable admission DES register.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners are Surrey Downs CCG and Surrey County Council. The providers are Epsom and St Helier NHS Trust, CSH Surrey, Surrey County Council and Voluntary Sector providers.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The various national pilots since 2008 for integrated services, the national pioneer schemes, Nuffield Institute Research reports, Sheffield Model for Discharge to Assess.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Plan 2015/16 £4,029,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribution to overall non-elective reduction of £2.6m for 2015/16.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The delivery of the Pathway will be monitored on a monthly basis via the Epsom Operational Group and reported to the SRG Board and the Local Joint Commissioning Group on a monthly

basis.
What are the key success factors for implementation of this scheme?
A reduction in delays reported daily as a result of system blocks or access and service waiting times. Reduced length of stay. Improved patient experience.

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Scheme ref no.
SD 4/48 (Projects 1,2,9,10b,11,12,16,17,20,23,37)
Scheme name
Rapid response/Intermediate Care/Reablement.
What is the strategic objective of this scheme?
To ensure there is an integrated and effective step up and step down continuum in order to effectively support people to be cared for and treated in their community rather than being admitted to the acute hospital.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To develop the local SCC Reablement service and CSH Community Hospitals by up skilling the workforce, creating additional capacity and integrating processes along the Discharge and Frailty Pathway in order to provide a comprehensive and readily available step up and step down continuum for the Surrey Downs area.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners are Surrey Downs CCG and Surrey County Council. The providers are SCC and CSH Surrey.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The national integrated care pilots 2008, the national pioneers 2014, the Nuffield Health Research etc.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Plan 2015/16 £3,071,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribution to overall non-elective reduction of £2.6m for 2015/16.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The delivery of the scheme will be monitored by the Local Joint Commissioning Group and the Operational Group and reported to the Transformation Board.
What are the key success factors for implementation of this scheme?
There will be an increased volume of referrals to Reablement and Community Hospitals from G.P's as step-up services to prevent admission and an increased rate of referral and access to

these services from the acute hospital to demonstrate a more responsive and effective discharge process. Success depends on effective integration, appropriately skilled workforce, capacity and professional referral behaviour.

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Scheme ref no.
SD 5/49 (Projects 3,6,7,19,28,32,33,34,35,36)
Scheme name
Integrated Services.
What is the strategic objective of this scheme?
To integrate and streamline a range of services in order to better prevent admission, facilitate effective discharge, eliminate duplication of functions and improve the patient experience.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There will be an integrated multi- disciplinary team with both health and social care functions and services. The model of care and support will include a streamlined, single assessment and effective care navigation with in-reach and out-reach elements. The patient cohort will be the frail elderly and/or complex and at risk of repeated avoidable admission to hospital.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The commissioners are Surrey Downs CCG and Surrey County Council. The providers are SCC, CSH Surrey, SABP and the Voluntary Sector.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
2008 national integrated care pilots, 2014 national pioneers programme, Nuffield Institute report of findings, Kings Fund 2012 Review.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Plan 2015/16 £7,728,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Contribution to overall non-elective reduction of £2.6m for 2015/16
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The scheme has an inter-agency project steering group and this will report into the Local Joint Commissioning Group and the Transformation Board.
What are the key success factors for implementation of this scheme?
Effective inter-agency integration, clear operational processes and procedures, clear governance arrangements, appropriate skill mix of teams, capacity, effective management of change and inter- agency trust and willingness will all result in delivering a clearly integrated service.

Surrey Heath CCG

Scheme ref no.
SHCCG BCF Integrated Care
Scheme names and strategic objectives :
Scheme 1: Admission avoidance To provide services and support to members of our community which prevent the need to access acute hospital services that result in an emergency admission. Focus: risk stratification, joint care planning and recording, community resilience and improved crisis management. **Scheme 2: Early return home from hospital** Improve discharge planning and intermediate community services to support more timely discharge from hospital Focus: In reach services, intermediate care, discharge planning (assessment and placement), early supported discharge, **Scheme 3: Nursing and residential support** Activities and investments specifically focused on preventing emergency admissions from nursing and residential homes and enabling earlier return home from hospital. Focus: Nursing and residential home education and training, GP lead risk assessment, improved assessment and placement processes into nursing and residential homes **Scheme 4: Rehabilitation and re-ablement** Reviewing and improving the services provided locally by social care which help people live independently in their own homes. Focus: Social care rehabilitation and re-ablement services including social care intermediate care beds (step up and step down)
Overview of the scheme - Integrated Care (Applies to all schemes)
"Integrated care seeks to close the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless. Source: Integrated Care: A Guide for Policy Makers **Model of Care and support – Integrated Care Teams** Integrated health and social care teams configured around GP practices, which focused on people with one or more long-term conditions. Supported by a local single point of access which includes a multi-agency team with the authority to signpost members of the community and professional to a range of services, including health, housing, social care, benefits and community development. The service will be delivery from four general practice basis across Surrey Heath – three Integrated Care Team (ICT) bases and one single point of access.

Initially the integrated care team will support older people with long term conditions in the community. The identification of people who might benefits from this service will be supported by the risk stratification tool.

The delivery chain

The commissioners involved include Surrey Heath CCG, and Surrey County Council. There is close working with Surrey Heath Borough Council who commission some interfacing services.

The providers involved include: Frimley Park Hospital NHS Foundation Trust (acute health provider), Surrey and Borders Partnership NHS Foundation Trust (mental health provider), Virgin Care LTD (community health provider), Surrey Heath Adult social services, and Voluntary Support (local voluntary services coordinator).

Appendix A provides evidence of the roles and responsibilities assigned for delivery and implementation of the scheme. (see Strategic Steering Group and Project Group)

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The evidence base

The project team has spent the last 12 months visiting pilot sites and exploring best practice examples of provider health and social care integration. This evidence has been used to support our planned approach to integrated care overall. Some of the evidence used is listed below:

An integrated care approach was chosen based on the following drivers – all of which are applicable locally

- *Integrated care addresses the changing demand for care*
- *Integrated care recognises that health and social care outcomes are interdependent*
- *Integrated care is a vehicle towards social integration of society's more vulnerable groups*
- *Integrated care may lead to better system efficiency*
- *Integrated care may improve the quality and continuity of care*

The evidence base for integrated care still requires more research and over a longer timeframe – some benefits will take many years to measure. The review of available evidence shows that integrating care is yielding results such as reduction in waiting times and duplication of services. There is some evidence of reduction in elective admissions and outpatient attendances. Case management demonstrated some reduction in overall secondary care costs and there was evidence of reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65 and minimal delayed transfers of care. Case management has also resulted in a reduction in use of residential and nursing homes and an associated increase in use of home care services.
There is general consensus that person-centred, population-based care with both vertical and horizontal integration health and social services, with a single point of entry and one assessment process, offers the greatest benefit. The research below highlights examples of reduced demand for hospital based services and nursing/residential home care, improve efficiency and quality but most reports identify a need for further analysis. The greatest benefits have been seen for older people with complex conditions where integrated care is particularly beneficial where used in prevention and the management of chronic diseases. It is in these areas that integrated care, provided within the community, can provide the care needed to maintain autonomy and the highest possible levels of functional capacity and well being of the older person.

NHS Commissioning Board	Care in local communities: A new vision and

	model for district nursing. Jan 2013
Mental Health Foundation	Crossing Boundaries: Improving integrated care for people with mental health problems. Sept 2013
National Collaboration for Integrated Care and Support	Integrated care and support: Our shared commitment. May 2013
Nuffield Trust	Evaluating integrated and community based care. June 2013
Local Government Association	Integrated Care Value Case Greenwich England. Nov 2013
Local Government Association	Integrated Care Evidence review. Nov 2013
Kings Fund	Integrated health and social care. Torbay Case Study. March 2011
Kings Fund	Making best use of the Better Care Fund. March 2013
Kings Fund	The quest for integrated health and social care. A case study Canterbury New Zealand. Sept 2013
NHS Tower Hamlets	Overview of the Integrated Care agenda Tower Hamlets March 2013.
Alliance for Health and the future	Integrated Care: A Guide for Policy Makers. 2013
Local Government Association	The Value case for co-ordinated health and social care.
Department of Health Ernst and Young	National Evaluation of the Department of Health Integrated Care Pilots March 2012

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

	Expenditure	
Scheme Name	**2014/15 (£000)**	**2015/16 (£000)**
Admission Avoidance (WSP)	572	572
Early return to Home from Hospital (WSP)	416	416
Nursing & Residential Home Support (WSP)	29	29
Rehabilitation & Re-ablement (WSP)	435	435
Enabling Support/Services (WSP)	97	97
Integrated Care Team		827
Integrated Care Team		643
Integrated Care Team		375
Scheme Name	**2014/15 (£000)**	**2015/16 (£000)**
Integrated Care Team		150
Reablement	500	500
Carers	178	178
Weekend working (ITC)		550

Weekend working (ITC)		400	
Weekend working (ITC)		250	
Weekend working (ITC)		79	

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan – work

Not yet completed.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

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Outcomes for the schemes have been aligned to the national metrics for the Better Care Fund. All are anticipated to improve patient experience. These will be monitored at a Surrey level through the Better Care Board and Surrey Health and Wellbeing Board. At a local level through the Local Joint Commissioning Group, and joint provider Integrated Care Strategy and Project Groups. Most of the metrics (still working through patients experience feedback) will be automatically generated with further granularity available through provider data sets.

Admission avoidance	Admissions to NH/RH ↓ Avoidable emergency admissions↓	Early dementia diagnosis ↓
Early return home from hospital	Delayed discharges of care ↓	Avoidable emergency(re) admissions↓
Nursing/residential home support	Admissions to NH/RH ↓	Avoidable emergency admissions↓ Early dementia diagnosis ↓ Delayed discharges of care ↓
Rehabilitation and Re- ablement	People still at home 91 days after discharge ↓ Delayed discharges of care ↓	
Enabling services/structures	Admissions to NH/RH ↓ Avoidable emergency admissions↓ People still at home 91 days after discharge ↓ Avoidable emergency admissions↓	

What are the key success factors for implementation of this scheme?

A recent case study by the King's Fund (2013) on progress with integration between health and social care in Canterbury, New Zealand identified three key success factors for change.

1. Creating a vision
2. Investment in providing people with the skills and time to innovate and support change
3. New forms of contracting

Within Surrey Heath we will focus on developing a shared vision with our local community and providers so that we can all be aligned in one direction. This is a significant challenge as health and social care have limited understanding of its others goals, operating context and use a different language! In additional our experience of partnership working with our local community is limited currently.

We recognise that co-design and implementing transformational change across health and social care will take new skills and capacity and we will put in place a local learning environment that will create a culture of innovation that supports new ideas and creativity.

We also recognise that the contracting environment can either act as a driver or block to innovation and will develop, with our providers, an environment that supports collective management of our system's resources and an emphasis on cost reduction not the chasing of revenue by providers.

We will take a system (whole health and social care economy) approach to the ITF challenge which will require collaborative working with other commissioners and organisational compromise. There is the "need for the whole system to be working for the system to work" (King's Fund 2013)

Further detail on our approach is given below:

- Creating a vision

There is overwhelming agreement from existing evidence that building a shared vision and goals across different providers or teams and establishing shared, trusted and respected clinical leadership is key to successful integration.

Approach: A co- design approach has been taken with providers and our local community. Clinical leaders have been identified within all providers. Each organisation will identify how the development of integrated care fits into and is consistent with other health and social care policy agendas and organisational priorities and strategies. A strong community and engagement programme will be in place.

- Provider capacity to innovate & benefits realisation

Capacity building **–** Lack of resources could limit the capacity of service providers to engage in this major organisational change and recruitment inhibit implementation. New integrated care models need to be financially sustainable. Sufficient investment needs to take place to enable the provision of integrated care, recognising that in the short-term the costs of implementing integrated care may exceed the economic future benefits.

Approach**:** Surrey Heath CCG is investing in provider capacity in 2014/15 (outside the Better Care Fund) in order to allow a period of capacity building prior to the requirements for economic benefits to be realised (From April 2015). Anticipated benefits will be closely monitored.

- Culture and co-operation

Integrated care requires that professionals from different sectors and backgrounds work and cooperate together. *Integrated care implies a movement away from the social care or health care culture towards a new culture and ethos of care*.

Various problems are anticipated:
• *Across professions:* Different professions will be working in close cooperation for the first time. Some professionals may resent such arrangements as a threat to their status. *Clashes in care cultures and priorities may arise.*
• *Across sectors:* resentment or a clash of ethos and culture may result when professionals from the public, private and voluntary sectors are required to work side-by-side.

Approach: Training will be given to professionals involved in the integrated care model to ensure optimal cooperation, mutual respect and understanding. Creating defined pathways of care in which the role of different professionals is clearly defined will be used.

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- Setting realistic implementation goals and strong programme management

Evidence shows that integrated care plans are sometimes advanced without careful consideration of the practical challenges they face in implementation. Closer attention to potential implementation challenges is required order to ensure success and viability of proposals. It is recommended that solutions that are adapted to local configurations of care and that are financially sustainable should be prioritised whenever possible.

Approach: The Surrey Heath plan is building on the strengths of the existing health and social care system and leveraging the benefits of the system that is a “real community” with a high degree of co-terminosity and strong existing partnership relationships. The schemes will be well supported using a programme management approach and whole system partnership monies used to invest in joint project managers and structures between health and social care.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Surrey Health and Well Being Board
Name of Provider organisation	Surrey and Sussex Healthcare NHS Trust
Name of Provider CEO	Michael Wilson
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,018
	2014/15 Plan	12,888
	2015/16 Plan	12,115
	14/15 Change compared to 13/14 outturn	-1%
	15/16 Change compared to planned 14/15 outturn	-6.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	130
	How many non-elective admissions is the BCF planned to prevent in 15-16?	733

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No, the Trust does not agree with these BCF Plans. • Case for change received on the 19.9.14 • Signed documents to be returned by the 24.9.14 • No detailed activity assumptions received • Timeframe did not allow any review of the evidence which would give confidence in delivery of activity reductions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The impact assumes a net 7.5% reduction in FFCE's Q1 14/15 has seen a 1% increase in A & E attendance compared to Q1 13/14 and a 15% increase in emergency patients with a length of stay over two days. 14/15 CCG plan assumes a reduction in activity which is not being achieved. Some schemes outlined are already operational and new schemes are limited in detail.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	There is a risk if the current activity trends continue that this will lead to capacity constraints within the Trust which will ultimately lead to poor patient experience, safety, quality, clinical outcomes and an overall adverse impact

		on performance.

Name of Health & Wellbeing Board	Surrey Health and Well Being Board
Name of Provider organisation	Royal Surrey County Hospital
Name of Provider CEO	Nick Moberly
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17,860
	2014/15 Plan	15,521
	2015/16 Plan	10,115
	14/15 Change compared to 13/14 outturn	-13%
	15/16 Change compared to planned 14/15 outturn	-35%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	2135 (across entirety of GWCCG at all providers)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	5001 (across entirety of GWCCG at all providers)

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No - Despite good engagement with the CCG we continue to experience significant growth in non-elective activity in 2014/15 and so the 14/15 out-turn figure is likely to be well above the 14/15 plan figure shown above. As the change described above would require a reduction in the order of 40% we cannot confirm that the BCF plans as they currently stand will deliver the proposed 15/16 plan figures.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Our experience in 2014/15 is that despite strong partnership working with the CCG the demographic and demand pressures in the health economy mean that our non-elective activity is performing above plan levels. We therefore will need to agree a much more detailed plan with commissioners and other partners in the health economy before we could provide assurance that such a significant reduction in FFCEs could be achieved. We are however committed to working with partners to deliver significant reductions in non-elective activity and it is a key aim of our joint integrated care strategy to do just this. We recognise our responsibility to lead the provider community to come together in order to transform pathways and models of care.

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As we have not been able to validate the delivery plans for this level of reduction as yet then the implication on our services is not yet clear. We are however working with the CCG, Virgin care (the local community provider) and others to develop an integrated care organisation which will aim to remove significant emergency activity of this sort from the acute setting. We recognise the impact this would have on our fixed cost base and are planning for this.

Name of Health & Wellbeing Board	Surrey Health and Well Being Board
Name of Provider organisation	Frimley Park Hospital NHS Foundation Trust
Name of Provider CEO	Andrew Morris
Signature (electronic or typed)	Andrew Morris

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	12,132
	2014/15 Plan	11,828
	2015/16 Plan	11,260
	14/15 Change compared to 13/14 outturn	-2.5%
	15/16 Change compared to planned 14/15 outturn	-4.8%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	304
	How many non-elective admissions is the BCF planned to prevent in 15-16?	568

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For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not with the data (see below). We do of course support the principle of care closer to home and continue to work collaboratively with local CCGs and others on a whole system approach to moving this strategy forwards.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have experience significant growth thus far this year and we project a 2014/15 outturn of 13,104 FFCEs. Anticipating the same growth next year will give an expected outturn for 2015/16 of 14,155 FFCEs. We are not sighted on detailed BCF plans, but if they are as successful as planned above (-568 FFCEs), we would expect a 2015/16 outturn of 13,587 FFCEs. This is 2,327 FFCEs higher than the CCG expectation above (21% higher).
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have recently opened a new ward providing a number of additional emergency beds. Should this be insufficient we will be looking to generate additional emergency capacity through reducing length of stay and increasing morning discharges. We have plans to move medical records off site to create space for additional clinical capacity but this

		will unfortunately take some time to come to fruition. We may be able expand our early supported discharge scheme, to support more patients at home rather than in hospital beds.

Name of Health & Wellbeing Board	Surrey Health and Wellbeing Board
Name of Provider organisation	Epsom and St Helier NHS Trust (figures below are for the Epsom Hospital site only)
Name of Provider CEO	CHRISHA ALAGARATNAM
Signature (electronic or typed)	C Alagaratnam

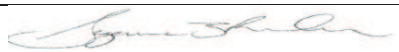
For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	12,683
	2014/15 Plan	12,526
	2015/16 Plan	11,756
	14/15 Change compared to 13/14 outturn	-157
	15/16 Change compared to planned 14/15 outturn	-6.1%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	-157
	How many non-elective admissions is the BCF planned to prevent in 15-16?	-770

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust fully supports the principles of the Better Care Fund and the schemes, developed jointly by Surrey Downs clinical commissioning group (SDCCG) and their partner agencies across Surrey, to implement integrated care for the local population. Detailed plans with clear objectives and agreed metrics across the schemes are in development. We would support a programme management approach to monitor the impact at point of delivery of each of the schemes and establish how best to correlate these with acute emergency activity data. We would encourage a focus on data quality and data capture across the schemes, enhanced by clinical audit and user experience feedback. This would enable us to build on this work to develop a monitoring framework that contributes to understanding the schemes that demonstrate the greatest impact. In tandem with this, it must be noted that meeting the reduction in non-elective admissions is dependent upon the community provider meeting their key performance indicators. A new operating model is in development by Surrey Downs CCG and the Trust would welcome the opportunity to be involved in the

		redesign of this service.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Surrey Downs has calculated the target reduction in non-elective admissions at 6.1%. This calculation was done by taking outturn, adjusting for demographic growth and non-demographic growth then taking off QIPP. We would like to note that we have seen a 5% growth in year of attendances at St Helier A&E, including the urgent care centre. Further consideration may need to be given to the changing landscape with the closure of some London A&E departments and the potential impact on other A&E departments, which in turn could impact upon Epsom Hospital. Contractually, the acute contract will remain as it is under PbR and any discussions regarding risk share and / or performance rewards will be from the default PbR position.

Name of Health & Wellbeing Board	Surrey Health and Well Being Board
Name of Provider organisation	Ashford & St Peter's Hospitals NHS Foundation Trust
Name of Provider CEO	Suzanne Rankin
Signature (electronic or typed)	

For HWB to populate:

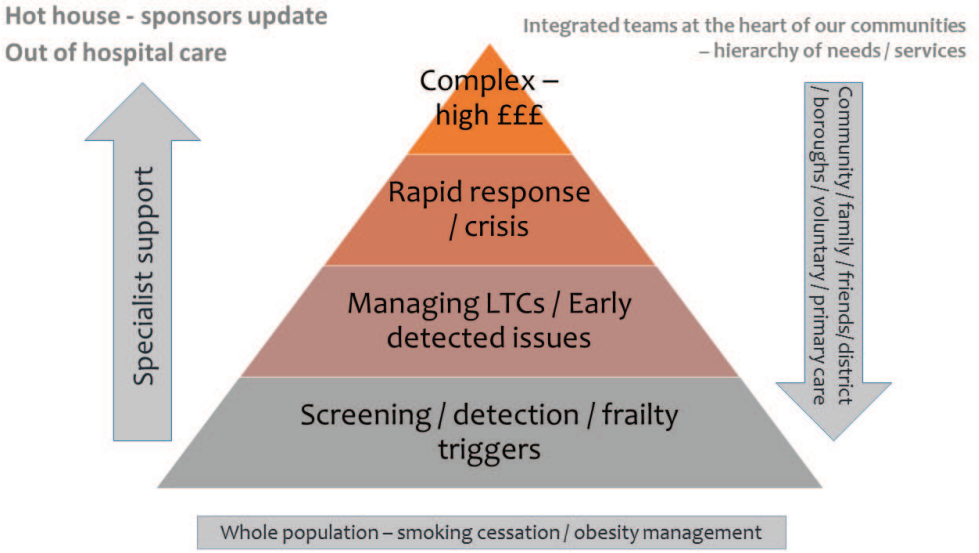
Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	*TBC*
	2014/15 Plan	97,669
	2015/16 Plan	93,813
	14/15 Change compared to 13/14 outturn	*TBC*
	15/16 Change compared to planned 14/15 outturn	3.9%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	*TBC*
	How many non-elective admissions is the BCF planned to prevent in 15-16?	3,856

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes for the most part but unable to fully verify as data set is incomplete.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Although the Trust recognises the data above for the most part, we have yet to see sufficiently robust supporting action plans to underpin an activity shift of this magnitude. We are however fully committed to, and engaged in, working up sufficiently robust plans with our CCG and Social Care partners to make the changes that are necessary.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

ANNEX 3 – Detailed enhanced BCF Scheme Descriptions

Scheme ref no.
eBCF 1
Scheme name
TOTAL TEAM - Out of Hospital Integrated Care Teams over 65's
What is the strategic objective of this scheme?
To drive an integrated model of provision across community health and local authority adult social care services in collaboration with the emerging GP Alliances across Surrey; this will include community mental health and CHC. This will avoid unnecessary duplication in the care pathway (e.g. duplicate assessments / visits) and maximise the benefits of a person centred integrated workforce, including information sharing, co-location, single assessment process, strengthened clinical leadership, and reskilling of the workforce. In the short to medium term it is anticipated that through more effective integrated team working and joint management, the experience of the public will be even more "joined up". This will result in a planned approach to delivering care, moving away from crisis management which will act as a mechanism to ensure services demonstrate value for money and are commissioned at the right price. Further longer term opportunities relate to shaping the market to improve quality and value for money from providers to enable effective procurement opportunities. Integral to the approach is supporting people to live well through strong connections with public health priorities and preventative services and support that district boroughs and the voluntary sector can provide. This work will transform care pathways, care at home and NHS Continuing Healthcare including proactively reviewing trigger points to service access, a greater emphasis on preventative care and the better use of technology to jointly manage and monitor long term conditions.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
In developing the BCF programme CCGs and SCC have invested time and resource into a 'Hot House' programme to draw upon organisational expertise to develop an agreed model of care that will benefit Surrey residents. In the 'Hot House' an initial high level opportunity assessment identified a potential range of benefits and the opportunity to enhance services by aligning local integrated delivery with GP alliance models that will serve to strengthen the response through better information sharing and stronger links to the domiciliary care market in each local area.



9

A proportion of our BCF relates to existing community based health services and there is a wider deployed fund packages of care. This transformation work stream will relate to the deployment of this resource in a model where better care costs less. The approach will accelerate:-

- Integrated delivery through the 6 Local Joint Commissioning Groups
- Workforce transformation in both the community providers and adult social care
- Estate and Asset utilisation through co-location
- Back office and support functions to reduce infrastructure costs

A detailed work programme is now being developed and will initially focus on opportunities for older people but will also include people of any age who are high resource users of health and social care (identified through systematic risk stratification). This will:

- Capture evidence of baseline review of skills and capacity across multidisciplinary teams.
- Identify opportunities for different workforce arrangements/teams to make efficiencies and improve effectiveness of the combined resources from each partner.
- Develop proposals to deliver workforce sharing across teams to reduce time spent on non-value-adding tasks enhancing efficiency and improving the service delivered, such as the trusted assessor model.
- Manage the implementation of the agreed workforce efficiencies proposals to ensure savings and improvements accrue during 2015/16
- Utilise alternative commissioning and contracting models

The outcome of this approach will strengthen delivery of integrated care. It will align the provider development with the ambitions of the BCF, in particular establishing sustainable local services as well as the opportunity to realise delivery of key programmes of the BCF plan including:-

- Promoting and maintaining healthy and independent living
- Developing early and proactive support in order to prevent health and social deterioration
- Empowering people with long-term conditions to live well, offering proactive, planned support to those with more complex needs
- Planned access to services in order to avoid emergency admissions
- Working in partnership with acute providers to deliver person-centred acute care
- Provide a discharge to assess model working with integrated community teams to return patients home once medically stable to enable assessments of need outside of an acute hospital

- Rehabilitation, reablement, therapies, community nursing and social work will be commissioned and delivered through a joint approach.
- CHC and FNC aligned and embedded with the work of Integrated Care Teams

Cost effective social care reablement

- Target reablement function to against a proportionate workforce skill base.
- Refocus the social care reablement service to be delivered to those most likely to benefit from the intervention, delivered by an integrated rehab/ rehabilitation service.
- Evaluate the potential to reduce the core offer of reablement.
- Extend the potential for reablement to be delivered through the independent sector, with incentivisation through contracts
- Identify reablement functions that can and should be delivered by the voluntary sector / LATC.
- Policy not to replace existing care packages with reablement workforce– the free service is the therapy support and equipment provision.

9

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery Chain:

- All 6 CCGs as potential participants as co-commissioners of primary care
- Virgin Care Ltd.
- First Community Health and Care
- CSH Surrey
- 5 Surrey acute trusts
- Surrey and Borders NHS Foundation Trust
- Surrey County Council
- District and Borough Councils x11
- Voluntary Sector
- Local Communities
- Independent sector

Evidence:

- Integrated commissioning – optimising collective power/joint approach.
- Analysing the market drivers and the incentives built into the market and highlight any saving opportunities that this presents.
- Embedding opportunities to streamline transfer/access points into care pathways (e.g. end of life care) and standardise pathways to reduce length of stay, reduce inter-provider and internal-provider referrals, and reduce market rates e.g. NHS CHC.
- Developing proposals to establish joint commissioning teams to drive greater efficiency, a single point of accountability of assessment, improved patient experience and consistent and coherent practice across all CCGs.
- Ensuring that the remit of Out of Hospital Integrated Care Teams is central within the whole pathway.
- Identify ways to facilitate and realise related efficiencies within the system.
- Support people more effectively to reduce their level of dependency on higher intensity care, e.g CHC and FNC
- Provide proposals for decision and implementation progress updates to the Better Care Board at the key stage points in the BCF programme timescales as well as monthly highlight report updates.

The evidence base

Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• Best practice examples of integrated care teams including Outer North East London, North West London, Torbay, Greenwich etc • National LTC programme evidence • Kings Fund, Nuffield Trust and Health Foundation academic studies • National Voices integration "I" statements • Oliver et al, 2014 • John Bolton LGA Use of Resources research "currently, too many people's assessment in a crisis leads to an extensive care package and runs the risk that the patient becomes care-dependent" • Canadian study showed that those older people who received small amounts of care had much greater needs for longer-term care and higher mortality rates than those who built personal resilience to manage their conditions • SCIE – Effective use of reablement
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
See Spreadsheet.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Improved outcomes for people • Empower people to co-produce their own care plans • People will receive a more joined up and responsive service • Reduce people's experience of fragmented care provision • Enabling people to live healthy and independently for longer • Reduce people requiring acute crisis support • Increasing people's access to planned, proactive care when needed • Effective reablement intervention **Improved commissioning benefits** • Commissioning opportunity to drive improvements in quality and standardise care costs taking advantage of jointly commissioned care at home • Opportunity to streamline transfer or access points to improve experience • Opportunity to integrate care and support of people with most complex needs and delivery across agencies • More effective integrated assessment and person (rather than organisation) centred care; • Re-ablement, ablement and independence achieved with fewer contacts. • Increased community resilience to support people that need low level skills gain work **Reduced service demand** • Potential to standardise care pathways to reduce length of stay and delayed discharge through discharge to assess. • Opportunity to optimise collective resources across CCGs and SCC including strengthening joint commissioning longer term • Increased demand will be met by re-designing how the service is delivered • Reduced acute emergency care through planned access to services

9

Reduced system costs

- More effectively realise benefits by managing care and support costs through a single integrated commissioning framework between health and social care.
- Avoid cost of duplication and system fragmentation
- Economies of scale – shared infrastructure, investment and management costs
- Ensure providers demonstrate value for money and are commissioned at the right price

Opportunities:

- Explore opportunities for joint/integrated procurement (i.e. reablement)
- Overarching PMO support at strategic level across CCGs and SCC which can provide dedicated support to the Better Care Board
- Consider engaging with expert advisors (e.g. King's Fund, Nuffield Trust, etc) to test assumptions and to expedite implementation
- Opportunity to enhance role of voluntary sector in the delivery of care and workforce up-skilling
- Consistent stakeholder communication across Surrey in order to mitigate potential risks

9

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcome-based framework
Clinical activity monitoring
BCF metrics
Patient experience and workforce feedback

What are the key success factors for implementation of this scheme?

- Financial modelling of impact
- Modelling of benefits in terms of service quality
- Communications / consultation with workforce and public about what to expect
- Joint commissioning
- SCC and CCGs being able to identify and extract detail of current activity from existing data
- Terms of engagement between community providers and Adult Services
- County-wide framework to support CCG Commissioning Intentions
- People in communities feel more confident about local services that can help them get "back on their feet"

Scheme ref no.
eBCF 2
Scheme name
Whole system Demand Management
What is the strategic objective of this scheme?
To reduce non-elective admissions by effectively using health and social care commissioning levers. Particularly focusing on nursing, residential and home based care. This will interface with all the other BCF projects.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Demand management with incentives for admission avoidance • Current fee levels in ASC not attractive to market, thus risk future joint tender for nursing care will fail • Utilise acute spend via admission avoidance to incentivise care home providers to reduce admissions Efficient use of contracting by CCGs and SCC to reduce hospital admissions. • Stop agreeing fee exceptions • Incentivise care homes to work with GP clinical networks to prevent acute admission • Merge Surrey health and social care market management and administrative functions for residential, nursing and domiciliary care • Indicate to the market that Surrey would like to reduce the volume of residential care and expand extra care; look at how local health and social care economy interfaces eg weekly clinic in extra care setting to promote admission avoidance • Use existing contracts more effectively to reduce admissions ie to improve contract compliance whilst residents are in hospital Work with Public Health to ensure: • Adequate robust health protection policies are in place and implemented in all nursing homes to prevent and adequately manage outbreaks such as norovirus. • All residents have adequate nutrition and hydration to prevent UTIs
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Health and social care commissioners Health and social care procurement functions Domiciliary care providers Voluntary sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• 6,700 non-elective admissions (including self-funders) across Surrey in 2011 from residential care and nursing homes

- Current duplication in the contract monitoring process
- Proposition of people in Surrey dying in hospital is higher than average
- Excess bed days

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

None

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

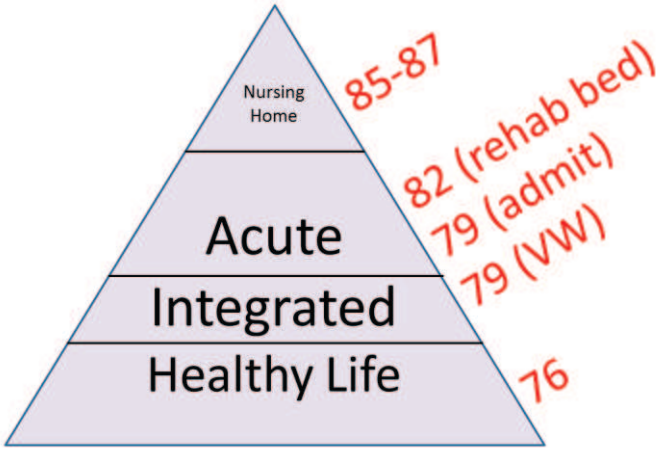
Reduce rate of admissions from each care home
Reduce excess bed days
Reduce hospital admissions
Reduce ED attendances
Reduce diagnostic requirements
Increase the proportion of people dying in their preferred place
Increase income
Improve user/carer experience
Reduce delayed transfers of care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Via aligned contract monitoring

What are the key success factors for implementation of this scheme?

Integration of health and social care commissioning
Communication
Coordinated contract Management

Scheme ref no.
eBCF 3
Scheme name
Mission 90: Commisioning framework for voluntary services
What is the strategic objective of this scheme?
Enabling people over 75 to stay healthy and independent at home for one year longer
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrating current health and social care voluntary services spend by developing commissioning services based on an agreed an outcome framework with both qualitative and quantitative measures aiming to help keep older people (75+) healthier happier and more independent in their home.    Effective use of resources integrating and consolidating the commissioning processes and outputs from the voluntary sector Formal link to the out of hospital commission team Robust integrated commissioning of such services will increase measurable quality of service provision Potential to engage volunteer workforce linked to friends, family and community and dementia friendly, which include a high proportion of over 75 year olds
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
6 Surrey CCGs Surrey County Council Voluntary and third sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme

- to drive assumptions about impact and outcomes
JSNA: Most costly services last 10 years of life (76yo plus) Current healthy life expectancy is 76 Clear evidence base for effective delivery Mission 90 will reduce service demand
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
See Spreadsheet.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Reduction in permanent admissions of older people to residential and nursing care homes, resulting from an increase in the age of admission • Enablement of voluntary services • Reduced emergency activity
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
BCF metrics: admissions to care homes, dementia Patient experience and workforce feedback
What are the key success factors for implementation of this scheme?
• Expansion and robust commissioning of voluntary sector • Co-design with stakeholders and public • Development of outcome commissioning framework

Scheme ref no.
eBCF 4
Scheme name
Call for Back-up (C4B) Crisis response services "Insurance", promoting the non-statutory prevention market
What is the strategic objective of this scheme?
To promote well-being and reduce anxiety for family and carers, which will result in decreased demands for health and social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Call for Back-up is a crisis response service linked to telecare that provides support from an appropriate agency to respond to a social care emergency or a non-injury fall. Different levels of interaction eg low level telephone befriending, health coaching, emergency response. To have senior review back up eg nurse/GP on Skype to aid decision making where needed.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Health and Social Care Commissioners Existing telecare provision by D&B Independent providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Pilot scheme undertaken in Surrey had good public engagement Similar schemes currently undertaken in UK
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Potential seed funding to be provided, but in-year recuperation to be agreed with provider
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduced ambulance call outs and Emergency department attendances

9

Promotes people's well-being Reduces anxiety of people and family Diverts demand on health and social care system Carer support / resilience Decrease GP and health visitor contacts
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Number of Call for back-up contacts Reduced ambulance call outs and Emergency department attendances
What are the key success factors for implementation of this scheme?
• User engagement • Provider market

9

The key milestones associated with the delivery of the four over-arching Surrey schemes are as follows:

October 2014

- Communicate draft commissioning intentions
- Agree and communicate finalised commissioning intentions to providers
- Define eBCF financial envelope
- LJCGs define leadership and programme management arrangements
- Review draft outputs from hot house
- Share current individual LJCG integration team plans across Surrey and confirm proposed launch dates
- Complete local baseline review of current services (including workforce and HR implications) across the six LJCGs in order to map resource, activity, and financial assumptions
- Set indicative resource and financial envelope both across Surrey and locally
- Establish an evaluation framework
- Conduct evidence-based review
- Reablement Change management process scoping
- Identify current lines of voluntary sector spend to include: Information advice hubs, Voluntary sector, D&B, Other community, CCG
- Market scoping / engagement (Mission 90, Call for Back-up)
- Adjust nursing care tender for joint integrated commissioning (Whole System Demand Management)

November 2014

- Define and agree Surrey-wide outcome framework and high-level specification including metrics
- Appraisal of commissioning and contracting models to support local implementation
- Surrey-wide peer review to test local proposals and potential contracting mechanisms (which can be tailored to local needs) at the Better Care Board and LJCGs
- Review estate implications of co-locating teams (Total Team)
- Co-design process with stakeholders/ users carers etc
- Agree concordat conference (Mission 90)
- Existing co-design to be revisited and refreshed (Call for Back-up)

December 2014

- Finalise LJCG shared commissioning plans and notify providers
- Local CCGs to agree requirements within contracts
- Communicate financial envelope with providers and agree target reductions in spend
- Better Care Board agreement (Call for Back-up)
- Agree plan for administrative integration (Whole System Demand Management)

January 2015

- Reablement tender (Total Team)

April 2015

- Go-live:
    - Total Teams
    - Mission 90
    - Call for Back-up

9

July 2015

- Go-live:
    - Reablement (Total Team)
    - Nursing care tender for joint integrated commissioning (Whole System Demand Management)

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Surrey

Please provide:

Kathryn Pyper
kathryn.pyper@surreycc.gov.uk

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Surrey

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	97,669
Change in Non Elective Activity	-977
% Change in Non Elective Activity	-1.0%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	1,455,268
Combined total of Performance and Ringfenced Funds	18,923,410
Ringfenced Fund	17,468,142
Value of NHS Commissioned Services	18,923,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	24,834	49,525	73,227	97,669
Cumulative Change in Non Elective Activity	-248	-495	-732	-977
Cumulative % Change in Non Elective Activity	-0.3%	-0.5%	-0.7%	-1.0%
Financial Value of Non Elective Saving/ Performance Fund (£)	370,027	367,896	353,160	364,186

Health and Wellbeing Funding Sources

Surrey

Please complete white cells

	Gross Contribution (£000)	
	2014/15	2015/16
Local Authority Social Services		
Surrey County Council	3,329	2,224
District and Boroughs		3,723
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**3,329**	**5,947**
CCG Minimum Contribution		
NHS Windsor, Ascot and Maidenhead CCG		540
NHS Surrey Heath CCG		5,501
NHS Surrey Downs CCG		16,398
NHS North West Surrey CCG		19,808
NHS North East Hampshire and Farnham CCG		2,601
NHS Guildford and Waverley CCG		11,230
NHS East Surrey CCG		9,397
Total Minimum CCG Contribution	**-**	**65,475**
Additional CCG Contribution		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**-**	**-**
Total Contribution	**3,329**	**71,422**

Summary of Health and Wellbeing Board Schemes

Surrey

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	-	18,923			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	3,329	35,973	3,329	25,000	Carers funding, Care Act obligations and capital funding
Other	-	16,526			
Total	**3,329**	**71,422**		**25,000**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		18,923
Continuing Care		-
Primary Care		-
Social Care		-
Other		-
Total		**18,923**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	-	
Increased effectiveness of reablement	-	2,422	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	-	1,455	1,455
Other	-	10,329	
Total	**-**	**14,207**	**1,455**

<Please explain discrepancy between D44 and E44 if applicable>

Health and Wellbeing Board Expenditure Plan

Surrey

Please complete white cells (for as many rows as required).

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
14-15 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	Local Authority Social Services	3,329	
ES									
ES - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		3,588
ES - Health Commissioned out of hospital	Community Health	Jointly agreed investment	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		2,507
ES - P4P Metric	Community Health	Jointly agreed investment	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		209
ES - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		368
ES - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		136
ES - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		353
ES - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		2,372
ES - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		534
ES - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		183
GW									
GW - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		4,288
GW - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		2,996
GW - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		250
GW - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		440
GW - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		162
GW - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		422
GW - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		2,834
GW - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		639
GW - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		219
NWS									
NWS - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		7,563
NWS - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		5,284
NWS - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		440
NWS - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		775
NWS - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		286
NWS - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		745
NWS - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		5,001
NWS - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		1,126
NWS - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		387
SH									
SH - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		2,100
SH - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		1,468
SH - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		122
SH - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		215
SH - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		79
SH - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		207
SH - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		1,389
SH - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		313
SH - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		107
SD									
SD - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		6,261
SD - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		4,374
SD - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		365
SD - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		642
SD - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		237
SD - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		617
SD - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		4,139
SD - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		932
SD - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		320
WA&M									
WA&M - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		207
WA&M - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		144
WA&M - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		12
WA&M - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		21
WA&M - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		8
WA&M - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		20
WA&M - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		136
WA&M - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		31
WA&M - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		11
NEH&F									
NEH&F - 15/16 Protection for Adult Social Care	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		993
NEH&F - Health Commissioned out of hospital services	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		695
NEH&F - P4P Metric	Community Health	Jointly agreed investment programme under development	CCG			Community/ Voluntary/ Social Care provider	CCG Minimum Contribution		57
NEH&F - Care Act (Revenue)	Social Care		Local Authority			Local Care Providers following national guidance	CCG Minimum Contribution		102
NEH&F - Care Act (Capital)	Social Care		Local Authority			Local Care Providers following national guidance	Local Authority Social Services		38
NEH&F - Carers	Social Care		Local Authority			Local Care Providers	CCG Minimum Contribution		99
NEH&F - Continuing Investment in Health and Social Care	Other	Jointly agreed investment programme under development	Joint			Determined after local negotiation	CCG Minimum Contribution		655
NEH&F - Disabled Facilities Grant	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		148
NEH&F - ASC Capital	Social Care		Local Authority			Local Care Providers	Local Authority Social Services		51
Total								**3,329**	**71,422**

Health and Wellbeing Board Financial Benefits Plan

Surrey

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

Benefit achieved from	If other please specifiy	Scheme Name	2014/15 Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
		Tab 4 HWB benefits Plan completion is dependent on the outcome of local joint commissioning group's im				-		
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Total						**-**		

2015/16

Benefit achieved from		Scheme Name	2015/16 Organisation to Benefit	Change in activity measure	Unit Price (£)	Total (Saving) (£)	How was the saving value calculated?	How will the savings against plan be monitored?
Reduction in non-elective (general + acute only)		Joint Whole System management of demand - Overall P4P Metric		977	1,490	1,455,268	Modelled with local acute providers	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - Reduce social care nursing fee exceptions by 50%	Integration of Health and Social Care - Reduce social care nursing fee exceptions by 50%		1	222,000	222,000	Joint analysis of placement costs for health and social care providers	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - Reduce CHC fee exceptions by 50%	Integration of Health and Social Care - Reduce CHC fee exceptions by 50%		1	73,000	73,000	Joint analysis of placement costs for health and social care providers	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Increased effectiveness of reablement		Integration of Health and Social Care - More effective procuring of reablement service - 30% saving in SCC reablement service cost		1	571,958	571,958	Reviewing potential models of alternative delivery	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - 5% saving on patient transport in Community Health provider contracts	Integration of Health and Social Care - 5% saving on patient transport in Community Health provider contracts		1	229,896	229,896	Benchmarking existing contract cost	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Joint whole system management of demand - Renegotiation of the hospital tariff for zero length stay and unbundling of community bed discharge tariffs	Joint whole system management of demand - Renegotiation of the hospital tariff for zero length stay and unbundling of community bed discharge tariffs		1	3,000,000	3,000,000	Modelled with local acute providers	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - Optimisation of care pathway - 10% shift down care settings	Integration of Health and Social Care - Optimisation of care pathway - 10% shift down care settings		1	660,000	660,000	Modelling of potential care pathways based upon increased intervention and prevention	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - 5% reduction in home care / district nurses contacts	Integration of Health and Social Care - 5% reduction in home care / district nurses contacts		1	2,119,442	2,119,442	Modelled on overall whole economy spend	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
						-		
Other	Integration of Health and wellbeing services - Diversion from social care - reduce demand from 6% to 3%	Integration of Health and wellbeing services - Diversion from social care - reduce demand from 6% to 3%		1	671,000	671,000	Modelling of potential care pathways based upon increased intervention and prevention	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - Integrated team efficiencies	Integration of Health and Social Care - Integrated team efficiencies		1	1,854,000	1,854,000	Modelled future local integrated team structure	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Increased effectiveness of reablement		Joint whole systems management of demand - Joint approach to reablement & rehabilitation services		1	1,850,000	1,850,000	Reviewed existing spend and scoped potential opportunities through integration	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Integration of Health and Social Care - Efficiencies in support & back office costs	Integration of Health and Social Care - Efficiencies in support & back office costs		1	500,000	500,000	Reviewed existing spend and scoped potential opportunities through integration	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
Other	Joint whole systems management of demand - Reduction in existing Whole Systems Partnership commitments	Joint whole systems management of demand - Reduction in existing Whole Systems Partnership commitments		1	1,000,000	1,000,000	Reviewing existing schemes to identify opportunities for reinvestment	Apply a project management approach to the planning of spend, identifying the funding sources and timescales, and measuring the outcomes and benefits achieved
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Total						**14,206,564**		

Surrey

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,138**	**2,126**	**2,040**	**2,104**	**2,099**	**2,087**	**2,003**	**2,066**	**2,060**
	Numerator	24,834	24,691	23,702	24,442	24,586	24,444	23,465	24,198	24,340
	Denominator	1,161,581	1,161,581	1,161,581	1,161,581	1,171,224	1,171,224	1,171,224	1,171,224	1,181,301
						P4P annual change in admissions		-977		
						P4P annual change in admissions (%)		*-1.0%*		
						P4P annual saving		*£1,455,268*		

Rationale for red/amber ratings: 1% improvement on the P4P (non-elective admissions) in 2014/15 and 2015/16 is a realistic stretch for Surrey on top of existing QIPP target stretches in place to reduce emergency admissions.

Please enter the average cost of a non-elective admission[1]: **£1,490**

Rationale for change from £1,490:

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)						Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	% CCG registered population that has resident population in Surrey	% Surrey resident population that is in CCG registered population	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Bracknell and Ascot CCG	2,477	2,205	2,276	2,388	1.8%	0.2%	44	39	40	42
NHS Bromley CCG	5,896	5,982	5,800	5,663	0.4%	0.1%	23	24	23	23
NHS Coastal West Sussex CCG	12,553	11,198	11,201	11,595	0.2%	0.0%	21	19	19	20
NHS Crawley CCG	3,005	2,884	2,863	2,928	6.6%	0.7%	198	190	189	193
NHS Croydon CCG	9,042	8,244	8,410	8,376	1.2%	0.4%	106	97	99	98
NHS East Surrey CCG	4,161	3,728	3,728	3,731	96.6%	14.1%	4,018	3,600	3,600	3,603
NHS Guildford and Waverley CCG	4,478	4,371	3,463	3,839	93.9%	17.0%	4,206	4,105	3,252	3,605
NHS Horsham and Mid Sussex CCG	4,957	4,160	4,200	4,243	1.6%	0.3%	80	67	67	68
NHS Hounslow CCG	6,036	7,003	7,050	7,054	0.5%	0.1%	32	37	37	37
NHS Kingston CCG	3,223	3,158	3,180	3,106	4.3%	0.7%	140	137	138	135
NHS Merton CCG	3,962	3,965	3,935	4,170	0.2%	0.0%	9	9	9	9
NHS North East Hampshire and Farnham CCG	4,479	4,277	4,247	4,433	23.1%	4.2%	1,033	987	980	1,023
NHS North Hampshire CCG	4,520	4,272	4,276	4,444	0.1%	0.0%	6	5	5	6
NHS North West Surrey CCG	6,618	7,629	7,712	7,712	99.5%	29.5%	6,584	7,589	7,672	7,672
NHS Richmond CCG	3,285	3,231	3,106	3,249	0.4%	0.0%	13	13	12	13
NHS South Eastern Hampshire CCG	4,426	4,443	4,371	4,507	0.1%	0.0%	5	5	5	5
NHS Surrey Downs CCG	6,261	5,790	5,579	5,823	97.2%	23.9%	6,084	5,626	5,421	5,658
NHS Surrey Heath CCG	1,931	1,882	1,867	1,948	99.2%	7.6%	1,916	1,867	1,852	1,933
NHS Sutton CCG	4,266	3,807	3,860	4,140	1.2%	0.2%	50	45	45	48
NHS West Kent CCG	9,942	9,073	9,173	9,173	0.2%	0.0%	23	21	21	21
NHS Windsor, Ascot and Maidenhead CCG	3,144	2,706	2,751	2,953	7.8%	1.0%	245	211	214	230
Total						**100%**	**24,834**	**24,691**	**23,702**	**24,442**

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Surrey

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual rate	585.9	566.6	547.3
	Numerator	1,190	1,214	1,197
	Denominator	203,275	214,253	218,723
	Annual change in admissions		24	-17
	Annual change in admissions %		2.0%	-1.4%

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	69.6	72.2	74.6
	Numerator	360	372	384
	Denominator	515	515	515
	Annual change in proportion		2.6	2.3
	Annual change in proportion %		3.8%	3.2%

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	793.1	736.1	807.0	736.1	783.8	727.4	797.5	721.6	773.0	717.5	786.6	711.7
	Numerator	7,137	6,624	7,262	6,678	7,110	6,599	7,235	6,599	7,069	6,561	7,193	6,561
	Denominator	899,844	899,844	899,844	907,172	907,172	907,172	907,172	914,467	914,467	914,467	914,467	921,915
								Annual change in admissions	-158			Annual change in admissions	-159
								Annual change in admissions %	-0.6%			Annual change in admissions %	-0.6%

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline Apr-Jun 2013	Planned 14/15 (if available)	Planned 15/16
Friends and Family Test (Inpatient) -PROVISIONAL	Metric Value	94.8%	#VALUE!	#VALUE!
	Numerator	6549	TBD	TBD
	Denominator	6906	TBD	TBD
Improvement indicated by:	Increase			

Local Metric

Metric		Baseline Apr-13 to Mar-14	Planned 14/15 (if available)	Planned 15/16
Estimated diagnosis rate for people with dementia (Surrey target)	Metric Value	47.3	54.7	66.7
	Numerator	7,235	8,372	10,294
	Denominator	15,290	15,291	15,441
Improvement indicated by:	Increase			

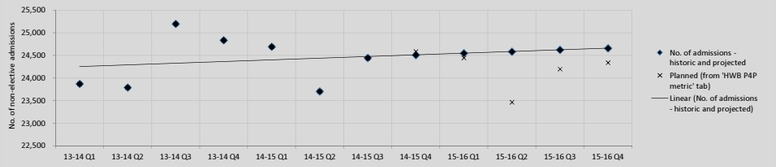
Surrey

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	23,868	23,790	25,195	24,834	24,691	23,702	24,442	24,509	24,546	24,583	24,620	24,657

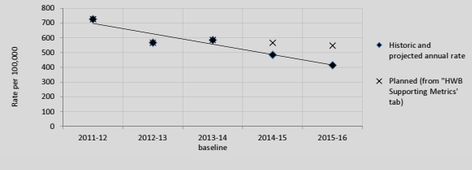


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,110.0*	*2,095.8*	*2,098.9*	*2,102.1*	*2,087.3*
	Numerator	*24,509*	*24,546*	*24,583*	*24,620*	*24,657*
	Denominator	*1,161,581*	*1,171,224*	*1,171,224*	*1,171,224*	*1,181,301*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

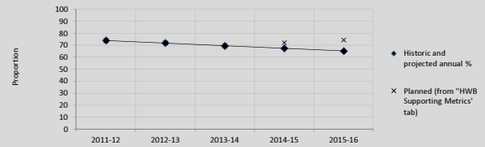
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	727	568	586	*486*	*415*
	Numerator	1,425	1,155	1,190	*1,041*	*908*
	Denominator	196,140	203,275	203,275	*214,253*	*218,723*



This is based on a simple projection of the metric proportion.

Reablement

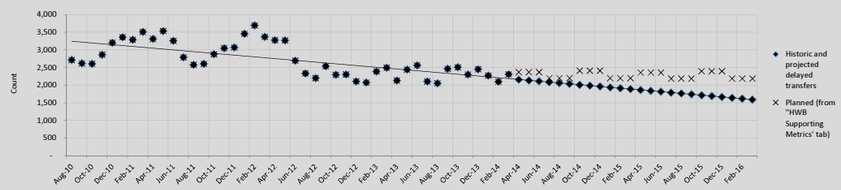
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	74	72	69.6	*67.5*	*65.3*
	Numerator	250	225	360	*347*	*336*
	Denominator	335	315	515	*515*	*515*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	2,715	2,619	2,608	2,867	3,205	3,362	3,289	3,511	3,313	3,539	3,259	2,788



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*706.0*	*681.5*	*657.0*	*627.5*	*603.2*	*578.9*	*554.6*	*526.0*
	Numerator	*6,405*	*6,183*	*5,961*	*5,738*	*5,516*	*5,294*	*5,072*	*4,850*
	Denominator	*907,172*	*907,172*	*907,172*	*914,467*	*914,467*	*914,467*	*914,467*	*921,915*

* The projected rates are based on annual population projections and therefore will not change linearly

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/14	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/14	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/14	HWB ID	J2	Changed to Version 2
28/07/14	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/14	a	AP1:AP348	Allocation updated for changes
28/07/14	All sheets	Columns	Allowed to modify column width if required
30/07/14	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/14	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/14	6. HWB supporting metrics	D19	Comment added
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/14	Data	Various	Changed a couple of 'dashes' to zeros
30/07/14	5. HWB P4P metric	H14	Removed rounding
31/07/14	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/14	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/14	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/14	5. HWB P4P metric	H13	Apply conditional formatting
01/08/14	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/14	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/14	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/14	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/14	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/14	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/14	a	M8	Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
13/08/14	HWB ID	J2	Changed to Version 3
13/08/14	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions'*
13/08/14	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/14	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion'*
13/08/14	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/14	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D18-C18)*
13/08/14	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	E21	Change formula to *= if(E19=0,0,E18-D18)*
13/08/14	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D18/C18-1)*
13/08/14	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E18/D18-1)*
13/08/14	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/14	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/14	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/14	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab