7

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

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

b) Authorisation and signoff

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

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

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

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

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

Signed on behalf of the Clinical	NHS Surrey Heath CCG

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

7

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

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

c) Service provider engagement

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

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

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

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

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

spring.

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

7

d) Patient, service user and public engagement

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

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

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

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

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

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

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

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

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

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

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

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

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

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e) Related documentation

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

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

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

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

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

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

This will mean:

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

Our shared values are:

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

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

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

- Investment in primary care
- Investment in community health services

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

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

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

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b) Aims and objectives

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

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

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

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

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

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

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

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Our over-arching objectives will be to ensure we:

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

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

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

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

c) Description of planned changes

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

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

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

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

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

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

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

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

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

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

hours services

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

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

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

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

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

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

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

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

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

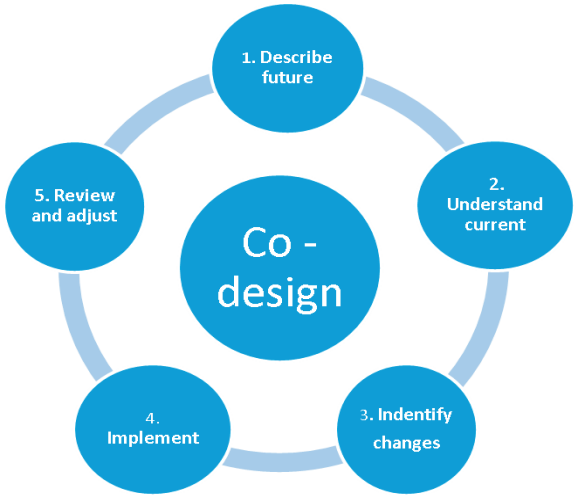
The County Council will take a co-design approach to ensure Surrey is ready to meet new duties under the Care Bill. This will include:

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

The key success factors will be:

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

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



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

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

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The anticipated time frames for delivery are proposed as:

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

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

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

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

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

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

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

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

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

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d) Implications for the acute sector

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

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

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

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

e) Governance

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

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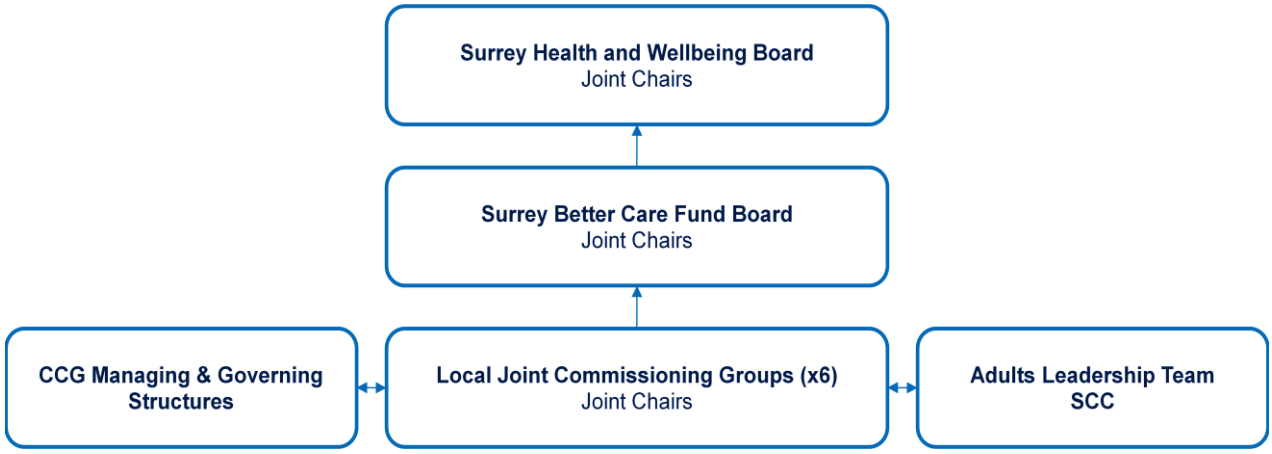
The governance arrangements in place for oversight and governance of progress and outcomes are as follows:

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



3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

b) 7 day services to support discharge

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

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

Progress has already been made, with for example:

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

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

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

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

7

c) Data sharing

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

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

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

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

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

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

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

7

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

d) Joint assessment and accountable lead professional

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

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

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

4) RISKS

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

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

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

7