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 and Farnham CCG straddles the counties of Surrey and Hampshire. The CCG has worked in collaboration with both Surrey and Hampshire County Councils and is included in both Local Authority Better Care Fund returns. The CCG's financial allocation has been appropriately split across the two Better Care Fund areas based on population. The CCG has aligned both templates to ensure inequality is minimised. • Due to the nature of patient flow, there are boundary issues that have been considered for East Surrey CCG. The Surrey and Sussex Healthcare NHS Trust contract - East Surrey's main acute provider is commissioned with Sussex • The population of Windsor, Ascot and Maidenhead CCG crosses Surrey in a very small area. The CCG is consequently making a small contribution to the Surrey Better Care Fund but does not form part of the Surrey planning area • The population of Guildford and Waverley crosses West Sussex in a very small area. Guildford and Waverley CCG is working with the Council and CCG's by contributing to their plans
Date agreed at Health and Well-	**2014**

Being Board:	
Date submitted:	**2014**
Minimum required value of BETTER CARE FUND pooled revenue budget: 2014/15	**£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	2014

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

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

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

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

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

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

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

By Chair of Health and Wellbeing Board	Councillor Michael Gosling Dr Joe McGilligan
Date	2014

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

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

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

Specifically:

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

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

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

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

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:

East Surrey CCG	East Surrey CCG consultations have continued with patients and the public from the initial 2013/14 commissioning plan development, regarding future intentions, including regular meetings with the Patient Reference Group (PRG). This helped shape and validate priorities for the locality, which will be further developed, implemented and embedded during 2014/15. The current Chairman of the PRG is also a member of the Governing Body, ensuring two way communications between the CCG and patient representatives. They also have a well-established Patient Reference Group that has been in place for over 2 years and consists of patients from each of their member practices. They are currently engaging local communities through a series of public meetings. These meetings

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

	organisations and members of the public. Meetings in June and September 2013 highlighted the importance the community places on more integrated services across health and social care and have influenced the programmes and projects within the local Better Care Fund plan. The Better Care Fund plan will be integrated into the work at borough level through the local Health and Wellbeing Board with key project/intervention being part of our Surrey Heath Partnership Plan. The Surrey Heath Partnership includes representatives from the voluntary and faith sectors, housing, fire services, local business and the police as well as other statutory agencies. An example of how housing services are already integrated into plans is demonstrated in the Supplementary Submission Information in the related documents section. Better Care Fund integration with community safety objectives (police) will also be achieved through this plan. Joint working with the police already takes place at a local level including the sharing of data to reduce A&E attendances.
Surrey County Council	For Adult Social Care, the mechanisms for engagement include representation from the Surrey disabled people's organisations and Action for Carers Surrey on the overarching Transformation Board and Implementation Board, along with representation on specific project boards and involvement in the development of commissioning priorities.

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

e) Related documentation

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

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

Document or information title	Synopsis and links
Surrey wide	
Surrey's Joint Health and Wellbeing Strategy	Sets out the five priorities upon which partners will work together to deliver an innovative and effective health and social care system for Surrey
Surrey's Joint Strategic Needs Assessment	How the CCGs and Adult Social Care identify and describe the health, care and well-being

Document or information title	Synopsis and links
	needs of the Surrey population. This assessment is used to inform the prioritisation and planning of services to meet those needs
Adult Social Care Directorate Strategy 2013/14–2017/18	The broad strategic direction for Surrey County Council's Adult Social Care Directorate over the next 5-years
Local Commissioning Intentions	Commissioning priorities/intentions of each of the Clinical Commissioning Groups and Surrey County Council
Local Health Profiles	Overview of the local CCG's population in terms of demography, deprivation and specific conditions and behavioural risk factors. Designed to assist CCGs to develop their commissioning intentions
Adult Social Care Commissioning Strategy for older people in Surrey 2011-2020	The broad strategic direction for Surrey County Council's Adult Social Care Commissioning Service for older people over the next 9 years
Surrey's Ageing Well Commitment	Describes what ageing well means and what kind of place Surrey needs to be to make it somewhere that people want to live and age in. Challenge our views of older people and looks at the many positives that older people bring to local communities
Surrey's Joint Older People Action Plan	Joint action plan to deliver the 'improving older adult's health and wellbeing priority' set out in Surrey's Joint Health and Wellbeing Strategy
Dementia and Older People's Mental Health Joint Commissioning Strategy	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey for Dementia and Other People's Mental Health over the next 5 years
Joint Commissioning Strategy for Adults with Long Term Neurological Conditions	Joint strategic direction for the Adult Social Care Commissioning Service, NHS Surrey and Neurological Commissioning Support for Adults with Long Term Neurological Condition over the next 4 years
Joint Commissioning Strategy for People with Sensory Impairment 2011-2015	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey for People with Sensory Impairment over the next 4 years
Joint Accommodation Strategy for people with care and support needs	Joint strategic direction for the Adult Social Care Commissioning Service and the 11 Districts and Boroughs on housing for people with care and support needs over the next 4 years
Joint Commissioning Strategy for Advocacy 2012-2016	Joint strategic direction for the Adult Social Care Commissioning Service and NHS Surrey on Advocacy over the next 4 years
Adult Social Care Information and Advice Strategy	Strategic direction for the Adult Social Care Directorate and documents current provision of information and advice services from 2010-2013
East Surrey CCG	
East Surrey CCG Strategic Plan 2014/15-	Describes the vision of the CCG and blue print

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

Document or information title	Synopsis and links
	the discharge component of the frail elderly pathway
Guildford and Waverley CCG planning objectives 2014/15	We have objectives for our population which includes measures of health gain, quality premiums, and productivity gains
Guildford and Waverley CCG Primary Care Plus+ Strategy, overview, Co-design report and project timeline for the implementation, risk log and integrated workforce planning template	A model for the operational integration of services with Primary Care
Guildford and Waverley CCG stakeholder engagement project timeline	Timeline sets out our stakeholder engagement activities for the Better Care Fund
Guildford and Waverley CCG Unplanned Care Acute Care Changes Better Care Fund Changes	Describes the detailed impact on the acute sector
Guildford and Waverley CCG Risk Log	Key risks associated with the Better Care Fund
Guildford and Waverley CCG Urgent Care Strategy	Describes the future system of access urgent care including A&E
Guildford ad Waverley CCG Better Care Fund Delivery and Implementation Group Terms of Reference	Terms of Reference for the local joint commissioning delivery forum for the Better Care Fund
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
North East Hampshire and Farnham CCG	
North East Hampshire and Farnham CCG 5 Year Vision	Vision and commissioning strategy for 2014 to 2019
North East Hampshire and Farnham CCG System Transformation Programme	Transformation Programme across the Frimley System in collaboration with NHS Surrey Heath CCG and NHS Bracknell and Ascot CCG
North East Hampshire and Farnham CCG Vision for Primary Care	System wide vision for the involvement and development of Primary Care services
North East Hampshire and Farnham Integration Programme Plan	
North East Hampshire and Farnham CCG Report on Stakeholder Event	Feedback from local stakeholder event demonstrating influence on joint Better Care Fund plans
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
North West Surrey CCG	
North West Surrey CCG Expression of Interest for Seven Day Service Improvement Programme	A submission to the DH to become a pilot site developing seven day services for the Integrated Frail Elderly Urgent Care Pathway
North West Surrey CCG Strategic Commissioning plan	The strategic direction for NW Surrey for the next five years. Five main programmes of acute care, frailty, children and young people, planned care, mental health and learning disability, targeted communities

Document or information title	Synopsis and links
North West Surrey CCG Expression of Interest in Prime Ministers Challenge Fund	A submission to the DH to become a pilot site to move forward with enhancing delivery of primary care over our three localities
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Surrey Downs CCG	
Surrey Downs CCG Out of Hospital Strategy	This strategy focuses on plans to increase investment in community services in Surrey Downs so that more people can receive care closer to their own homes
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme
Surrey Heath CCG	
Surrey Heath CCG Engagement Timeline	
Surrey Heath CCG Supplementary submission information	
Local Joint Better Care Fund Plan	Local joint health and social care Better Care Fund plan and work programme

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

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

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

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[1] JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938
[2] Projections: http://www.surreyi.gov.uk/RealmDataBrowser.aspx?GroupID=0&filterDataSetID=933
[3] JSNA summary: http://www.surreyi.gov.uk/Resource.aspx?ResourceID=938

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

Our vision and values

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

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

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:

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

5 POPPI: www.poppi.org.uk

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

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

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

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

- Engagement with providers
- Co-design and co-delivery with patients, service users and the public
- Investment in social care and other local authority services
- Investment in primary care
- Investment in community health services

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

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

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

b) Aims and objectives

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

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?

- What measures of health gain will you apply to your population?

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

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

The alternative and preferred option for local partners is to fundamentally transform the care system, to deliver high quality, timely interventions within the community or in hospital to support a greater proportion of people to remain within their own homes. This transformation cannot be achieved within a system of competition between agencies but requires more than simple co-operation.

Our aim

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

Our objectives

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

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

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

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

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

causes considered amenable to healthcare
- Improve care in sustaining independence and improving quality of life for people with dementia

Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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

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

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

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

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

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

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

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

   - Recognising the connections individuals have with their family, friends and local community networks, to support them to stay healthy, independent and to manage their own care

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

The key success factors will be:

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

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

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

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

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

- Establishing local integrated community teams organised around GP practice populations, either individually or in networks. This would include GPs, geriatricians, therapies, community health services, mental health services, social care, reablement, district and borough services and the voluntary sector
- Enhancing primary care services operating in networks of practices providing systematic medical leadership seven-days a week, including a review of out of hours services
- Redesigning the integrated frailty pathway, incorporating end of life, ensuring older and vulnerable people receive proactive support to keep them independent and well in their own home, and responsive care that delivers timely interventions to avoid the need for urgent or emergency care
- Continuing the focus on developing more integrated support for people with dementia and their carers, with for example the introduction of community based geriatricians and psycho-geriatricians to support elderly people with dementia
- Implementing a lead professional role for those people who are over 75 or most at risk of a hospital admission
- Providing a single patient centred care plan, which is electronically accessible to all relevant health and social care professionals
- Expanding provision of joint community based rehabilitation and reablement to help people recovering from an illness or set back (including post-stroke)
- Encouraging effective residential/nursing care home and home based care support to enable the independent sector to contribute to the effectiveness of the whole system and address admissions to acute care from these settings
- Ensuring effective urgent or emergency response services, including an urgent home assessment and treatment service (in partnership with the ambulance service), access to short stay beds and respite services, carers support in crisis, delivery of Keogh clinical standards for urgent and emergency care
- Providing seven-day, 24-hour services where needed to optimise the urgent care pathway
- Creating effective arrangements for continuing health care assessment and placement, including improving patient experience and outcomes, with for example

discharge to assess beds, joint health and social care assessments

- Focus on supporting people with dementia to live at home for as long as they choose

The key success factors will be:

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

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

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

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

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

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

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

The key success factors will be:

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

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

The Care Bill

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

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

Carers Support

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

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

Disabled Facilities Grant

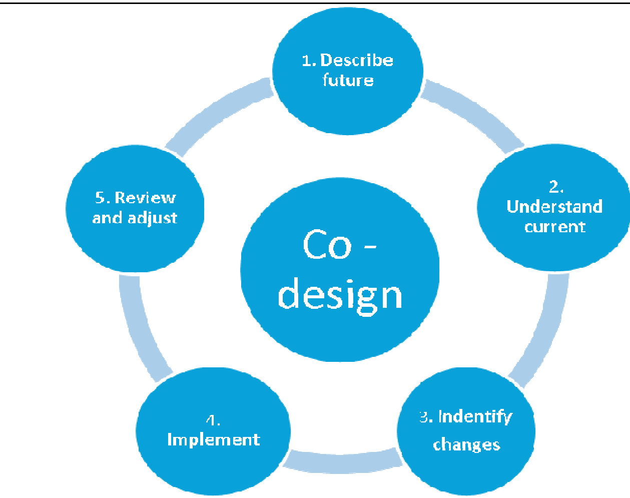
Surrey has committed to ring fence the Disabled Facilities Grant element of the Better Care Fund in 2015/16. The Local Joint Commissioning Groups will work with the 11 Borough and District Councils, as the local housing authorities, to ensure the provision of adaptation is incorporated into local investment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

Key enablers

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

- Systems leadership and joint local management, including programme and project management
- Development of personal health budgets and direct payments to promote patient independence with flexible tailored healthcare
- Provision of community equipment
- Optimisation of new/existing technologies to give people more control of their care
- Systems development and the introduction of systems which talk to each other
- Developing a Surrey health and social care workforce strategy and plan to ensure ‘skills for care’, leadership development, sufficient capacity and flexibility to meet future demand and a culture of innovation that supports new ideas and creativity. Specifically:
    - This Better Care Fund requires new ways of thinking about workforce competencies as part of an integrated model of care. Our care workforce will need to develop core competencies, which mean that any qualified professional can conduct holistic assessments that cover a person's health, social care, practical support and mental health needs.
    - As partners we are committed to working with Workforce Deaneries and Training Programmes in Health and Social Care to provide continuing professional development for existing staff and provide placements for trainees pre-registration training.
    - Our model promotes support that ensures people are treated by professionals with appropriate competencies to provide safe, personalised and effective care. We are working on where best to locate Senior Clinicians and Practitioners across our pathways to ensure people see a professional with an appropriate level of experience and decision making autonomy at the right point in their journey.

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



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

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

The anticipated time frames for delivery is proposed as:

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c) Implications for the acute sector

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

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

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

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

Specifically:

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

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

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

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

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

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

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

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

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

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

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

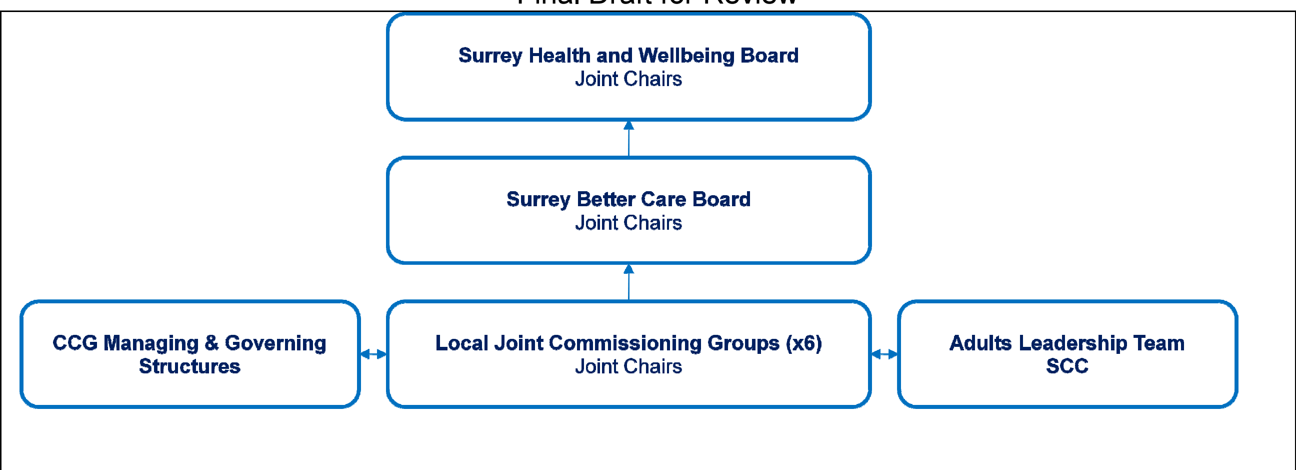
If savings are not realised in the acute sector once investment in community services is made, there is a risk that disinvestment in some areas of healthcare would be required, with risk sharing arrangements to be agreed. Contingency plans will need to be in place based upon a number of scenarios as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

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

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

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

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



3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

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

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

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

Progress has already been made, with for example:

Adult Social Care	• Social care staff working from 8.00am - 8.00pm Monday to Friday, 9.00am - 5.00pm Saturday and Sunday in all five of Surrey's acute hospitals, since October 2012 • Delivering reablement services 7.00am – 10.00pm over 7-days a week, supported by a night response service from 10.00pm • Developing a Market Position Statement to signal requirements to the wider market. This will include a refresh of commissioning strategies, specifications and terms and condition to ensure that the whole system, including the independent social care sector is aligned to the seven-day service objective
Guildford and Waverley CCG	Outline plans are in place for the integration of health and social care teams around practice populations as part of 'Primary Care Plus+' in Guildford and Waverley CCG, to operate 7-days per week with extended hours to 8.00pm. This key scheme will reduce approximately £8m of acute activity for the over 75's through integrating primary and community services, including social care and older adults mental health services. At a practice level this means increasing one additional facilitated discharge per practice per week, and avoiding three preventable ambulatory sensitive condition admissions every two weeks. Increased dementia liaison support to care homes will help to ensure the needs of people with dementia are considered. Rapid discharge and reablement are a critical element of this and will attract significant resources next year to support its success.
North West Surrey CCG	North West Surrey CCG have a model of urgent care and community service provision which will deliver services in the community through 3 community hubs, integrated primary and community care provision 7-days per week.

The commitment to seven-day services underpins the schemes and changes set out in the Surrey Better Care Fund. This commitment will be taken forward as part of Surrey's work to shape the new integrated model of community based health and social care. The next steps will be to:

- Analyse demand against capacity in the urgent care pathway - this will include for example, primary care (including GP out of hours services), psychiatric liaison services, pharmacy, crisis management intermediate care and reablement, hospital discharge services, and the capacity of home care providers, nursing and residential care homes to accept new

referrals across seven days
- Engage with patients, service users and frontline staff across all agencies to understand the opportunities, challenges and desired outcomes, ensuring that solutions are co-designed and co-delivered
- Understand the capacity in existing contracts and how this can be maximised
- Make local joint investment decisions that deliver the required changes

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

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

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

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

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

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

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

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

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

4) RISKS

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

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

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