Health and Wellbeing Board
10 September 2015

# Better Care Fund Position Statement

**Purpose of the report:** Scrutiny of Services and Budgets/Performance Management

This paper sets out a Better Care Fund Position Statements for each of the six Local Joint Commissioning Groups across Surrey.

## Introduction:

### What is the Better Care Fund?

1. The Better Care Fund (BCF) is a national programme which creates a local single pooled budget to support and enable closer working between the NHS and local government. It is designed to:

    a. Improve outcomes for people.
    b. Drive closer integration between health and social care.
    c. Increase investment in preventative services in primary care, community health and social care.
    d. Support the strategic shift from acute to community and to protect social care services.

2. The BCF should not be considered 'new' money - it is a pooling of existing funding streams including the Whole Systems Partnership funding that Surrey County Council (SCC) received in previous years from the Department of Health, funding from Clinical Commissioning Groups (CCGs) baselines and capital resources previously paid to SCC and Surrey's district and borough councils.

**What are we doing in Surrey?**

3. Surrey's BCF has been developed to ensure the services that we commission meet SCC and CCGs' shared strategic aims and programme objectives:
    a. 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
    b. 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
    c. 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

4. A 'local' approach has been taken to Surrey's BCF development - using six Local Joint Commissioning Groups (LJCGs) that have been established between SCC and the CCGs, schemes and plans have been developed that are appropriate for each local area based on local need. Through the plans, we are committed to achieving consistent, improved health and social care outcomes but recognise that to achieve that, the solutions may look different in each area.

**Who is making the decisions about the Better Care Fund?**

5. SCC and Surrey's six main CCGs have agreed a governance framework to support the implementation of the BCF – this describes the arrangements that have been established to ensure proper and effective management of the plans and funds.

6. Whilst the Surrey Health and Wellbeing Board is responsible for signing off the plan, the Council and each of the CCGs' Governing Bodies retain their statutory responsibilities for the use of resources and delivery of services.

7. In each area, LJCGs have been given the responsibility for developing and agreeing local plans and determining how funds for their area will be spent. A Surrey-wide Better Care Board has been established to work on behalf of the Health and Wellbeing Board to have oversight of the plan across Surrey.

**What is the funding?**

8. Surrey's BCF is £71.422m in total – of this £65.475m is revenue funding and £5.947m is capital funding. The table below shows the agreed distribution of funding (between CCG areas and broad areas of spend).

| £000 | Surrey Total | East Surrey 14.35% | Guildford & Waverley 17.15% | North West Surrey 30.25% | Surrey Downs 25.04% | Surrey Heath 8.4% | North East Hampshire & Farnham 3.97% | Windsor, Ascot & Maidenhead 0.82% |
|---|---|---|---|---|---|---|---|---|
| Protection of adult social care | 25,000 | 3,588 | 4,288 | 7,563 | 6,261 | 2,100 | 993 | 207 |
| Care Act (revenue) | 2,563 | 368 | 440 | 775 | 642 | 215 | 102 | 21 |
| Carers | 2,463 | 353 | 422 | 745 | 617 | 207 | 99 | 20 |
| **Subtotal (Adult Social Care & Carers)** | **30,026** | **4,309** | **5,150** | **9,083** | **7,520** | **2,522** | **1,194** | **248** |
| Health commissioned out of hospital services | 17,461 | 2,507 | 2,996 | 5,277 | 4,374 | 1,468 | 695 | 144 |
| Health commissioned 'in hospital' services | 1,462 | 209 | 250 | 447 | 365 | 122 | 57 | 12 |
| **Subtotal (health commissioned services)** | **18,923** | **2,716** | **3,246** | **5,724** | **4,739** | **1,590** | **752** | **156** |
| Continuing investment in health and social care | 16,526 | 2,372 | 2,834 | 5,001 | 4,139 | 1,389 | 655 | 136 |
| **Total revenue** | **65,475** | **9,397** | **11,230** | **19,808** | **16,398** | **5,501** | **2,601** | **540** |
| Disabled facilities grants | 3,723 | 534 | 639 | 1,126 | 932 | 313 | 148 | 31 |
| Care Act capital | 946 | 136 | 162 | 286 | 237 | 79 | 38 | 8 |
| ASC capital | 1,278 | 183 | 219 | 387 | 320 | 107 | 51 | 11 |
| **Total capital** | **5,947** | **853** | **1,020** | **1,799** | **1,489** | **499** | **237** | **50** |
| **Total BCF** | **71,422** | **10,250** | **12,250** | **21,607** | **17,887** | **6,000** | **2,838** | **590** |

9. Total SCC and CCG funding can be found at Annex 1.

10. The BCF is underpinned by seven pooled budgets and the agreed governance framework sets out contributions, how this money is used and how decisions on this spending are made. 'Section 75' legal agreements outline the arrangements for the pooling of these resources and the delegation of certain NHS and local authority health-related functions under the National Health Services Act 2006. SCC is managing the accounting arrangements for the pooled budgets on behalf of all of the CCGs. LJCGs for each CCG area are responsible for managing the pooled budgets for their areas and making decisions about how funding should be allocated.

11. All contributions to the pooled funds to the end of quarter 1 have been received and the allocated budget is forecast to be spent in full by the year end.

**East Surrey LJCG**

12. The East Surrey LJCG membership includes, officers from East Surrey CCG, SCC, Reigate & Banstead Borough Council and Tandridge District Council. The

meetings are co-chaired by the Area Director from Adult Social Care and the Director of Commissioning and Engagement from the CCG. The meeting is divided into two. The first half of the meeting includes invited guests, and progress updates are provided. The second part involves the core group.

13. The purpose of the group is to support the delivery of SCC and CCGs' shared strategic priorities and the aims of the BCF. They key areas we are focusing on include:-

    - Reducing Admissions and Promoting Swift and Integrated Discharge (RAPSID)
    - Integrated working
    - Signposting and Prevention

14. The group has the joint oversight of the BCF plan across East Surrey. This includes reviewing finance and performance for the services, contracts and grants within the BCF. It provides a platform to identify gaps and opportunities across East Surrey and jointly develop robust plans for the future.

**Integration in East Surrey**

15. Integrated Commissioning
    One Commissioning Team – commissioning for the whole East Surrey System. Development of key enabler work streams for successful integration premises /workforce/ IT/performance management & governance/payment mechanisms.

16. Integrated Assessment
    Trusted assessor model across the whole system with an agreed workforce profile, embedded in health and social care hubs, which will be fully integrated.

17. Integrated Urgent Care Team
    At the 'front door' of acute care - 24/7. Using the skills of the multi-agency, multi-disciplinary team for timely and complete assessment; Ambulatory pathways with access to diagnostics and specialist opinion avoiding ED attendances and emergency admissions. Development of one plan for one person.

18. Integrated Discharge Team
    Wrap around community services will action the Discharge to Assess process, with timely follow up from community health and social services. A bed-based care model with the independent sector, focusing on elderly frail patients with rehabilitation potential and those who may need continuing health care.

19. Shared System Enablers
    Access to shared primary & community care medical notes and care plans across the system. Interoperability between Hospital IT & GP/Community, Social Care IT systems. Partnership and Risk Sharing agreement overseen by system wide project board. Local tariff and payment model for the CCG.

## Guildford and Waverley LJCG

20. The Guildford and Waverley LJCG is made up of representatives from SCC and NHS Guildford and Waverley CCG as outlined in the governance framework. In addition, associate members from other organisations are invited as necessary. There is good representation from the CCG, SCC and Guildford and Waverley Borough Councils.

21. In order to meet SCC and the CCGs' shared strategic aims and programme objectives, the five areas of investment are:

    - Rapid Response Services
    - Virtual Ward Services
    - Telecare and telehealth
    - Social Care Reablment and Carers (includes protection of social care, carers and Care Act Funding)
    - Mental Health

22. The LJCG maintains joint oversight of the BCF plans across NHS Guilford and Waverley and SCC and in doing so makes the most of opportunities for synergies across health and social care.

### Integration in Guildford and Waverley

23. Integrated Care and Assessment Service (ICAS) - The ICAS service is based at the Royal Surrey County Hospital and is made up of all the discharge functions that have now been brought together as a distinct team under a single management structure. The social care team is an integral part of this team; on a day to day basis the team manager reports to the Head of Integrated Care to ensure that patients are discharged safely at the appropriate time thus reducing length of stay.

24. My Care, My Choice - Guildford and Waverley CCG has developed five locality hubs with primary care colleagues. This puts the resident, carer and their family at the centre and supports them to be involved in decisions around planning for their care. The social care teams are part of the multidisciplinary teams within the community. An operating model has been developed.

    There are five locality hubs as follows:

    - Haslemere (4 Practices)
    - East Waverley (5 practices)
    - North Guildford (3 practices)
    - East Guildford (4 practices)
    - Central Guildford (5 practices)

    The next steps are to develop proactive care teams that will respond to the needs of the individual and their carer thus supporting them to remain within the

community. The East Waverley locality will be the first locality to go live with the proactive care team model.

25. Rapid Response/Reablement - We are currently developing a Discharge to Assess model with our community health provider with a view to merging the Rapid Response and Reablement teams into a single service. This will also support the locality proactive care model.

**North East Hampshire and Farnham LJCG**

26. North East Hampshire and Farnham CCG were invited to bid to become a national pilot site for 'Vanguard' - The NHS new models of care programme. Bids were invited for four models: multispecialty community providers; primary and acute care systems (PACS); viable smaller hospitals as well as enhanced health in care homes. Twenty-nine pilots were selected and of that, North East Hampshire and Farnham were selected to be one of nine PACS models.

27. The Vanguard programme in North East Hampshire and Farnham is made up of clinicians and services managers from NHS North East Hampshire and Farnham CCG, Frimley Health NHS Foundation Trust, Southern Health NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, South East Coast Ambulance Service NHS Foundation Trust, Virgin Care, North Hampshire Urgent Care and Hampshire and Surrey County Councils. NHS North East Hampshire and Farnham CCG are the lead organisation for the programme.

28. The programme includes six key elements:

29. New model of care
    - Designed by care professionals and local people, will look and feel different.
    - There are different elements that will improve the model of care including integrated health and social care teams, support for self-care and helping to prevent ill health, enhanced community services and specialist inpatient (hospital) care.

30. Preventing ill health, enabling self-care and supporting wellbeing
    - Provide opportunities for people within the local community to access activities and support to help them manage their own conditions.
    - Helping people with mental health conditions with life skills such as budgeting and return to work support.
    - Provide greater support to carers.
    - Train pharmacy staff to give expert self-care and wellbeing advice and recognise this through the Healthy Living scheme.
    - Eliminating health inequalities in North East Hampshire and Farnham to ensure fair access to all health and social care services and support.

31. Integrated health and social care teams with hubs in every locality
    - Five integrated health and social care teams will be operating in Farnham, Fleet, Farnborough, Aldershot and Yateley by the end of July.
    - These teams comprise community nurses, occupational therapists, physiotherapists, social workers, a psychiatric nurse, a lead psychiatrist, a pharmacist, a geriatrician, GPs, the voluntary sector and specialists in palliative care and domiciliary care, supported by a dedicated Integrated Care Team Coordinator.
    - These health and social care professionals will work as a single team, meeting regularly to discuss patients and prepare a single coordinated plan to deliver joined up care for local people, especially the most vulnerable or complex patients.

32. New model of care in acute
    - Designed with secondary and primary care clinicians, patients and commissioners, a new model of care will speed up discharge and will provide rehabilitation services out in the community.

33. New Commissioning Model
    - Creation of new planning (commissioning) model for health and social care services
    - CCGs and the County Councils, along with NHS England will pool their health and social care resources (people, budget and services) for the local population.
    - These partners will draw up contracts with providers to fund improved long-term outcomes for patients and to enable the successful delivery of the new model of care.

34. New Provider Model
    - A new joined-up model for providers of health and social care services.
    - Providing more specialist care in the community to avoid patients being admitted to hospital where possible, and to help them be discharged home earlier.
    - Discussions between providers are underway of what model would be best suited to deliver the new model of care.

**North West Surrey LJCG**

35. The North West Surrey LJCG's membership includes officers from North West Surrey CCG, Adult Social Care and Public Health. On a quarterly basis we are joined by officers from Elmbridge, Runnymede, Spelthorne and Woking Borough Councils. The meetings are co-chaired by the Area Director for Adult Social Care and the Director of Quality and Innovation from the CCG.

36. The LJCG supports the delivery of our strategic priorities and the aims of the BCF. They key areas we are focusing on include:-

    - Developing Locality Hubs – integrated multidisciplinary teams of health and social care staff lead by Primary Care

    - Developing a Integrated Rapid Response Service – proactive discharge planning and admission avoidance

    - Prevention – working with Public Health and Districts and Boroughs, and voluntary sector building on Family Friends and Community support

37. The LJCG also has the joint oversight of the BCF plan across North West Surrey. This includes reviewing value for money performance outcomes for all contracts and grants funded from the Better Care Fund e.g., Carers services, all protection of social care services, telecare, telehealth, and stroke services.

38. The group provides a platform for whole system to identify opportunities for efficiencies and the improvement joint working initiatives that will improve health and well-being outcomes for local people.

**Integration in North West Surrey**

Developing Locality Hubs

39. Integrated multidisciplinary teams of health and social care staff lead by Primary Care.

40. The Locality Hubs are being developed around the three GP Locality Network Boards:
    - Stanwell, Ashford, Staines, Shepperton, Egham, Spelthorne - 13 practices
    - Thames Medical West, Elmbridge and Runnymede - 14 Practices
    - Woking 15 Practices, with the first hub being located at Woking Community Hospital.

41. The Hubs will provide proactive care, initially for a smaller cohort of people over 75 years with complex needs. The aim is to provide preventative support, to delay the need for more intensive health and social care support and prevent hospital admission. If admission occurs, the hub will ensure timely discharge.

42. The aspiration is to have one care record shared and owned across the health and social care system within North West Surrey.

Integrated discharge team

43. Joining up the health and social care discharge functions within St Peter's Hospital within one management structure.

44. The Community Medical Teams have been launched; these are allocated to each of the GP Locality Networks in Surrey Downs and will be key in providing medical leadership for the Community Hubs as well as support for the Rapid Response service.

Developing a Rapid Response/Reablement Service

45. We are exploring options to integrate with the community health provider (Rapid Response) and Reablement to compliment the proactive interventions planned with the locality hub model.

Prevention

46. Working with Public Health, Districts and Boroughs, and the voluntary sector. There are six strategic change programmes within the North West CCG area, the Targeted Communities Programme is working towards reducing health inequalities and prevention the targeted communities group is made up of made up of the CCG, Social Care, Public Health, Districts and Boroughs as well as the voluntary sector.

**Surrey Downs LJCG**

47. The Surrey Downs Group LJCG membership includes, officers from Surrey Downs CCG, SCC, Adult Social Care and Public Health. On a quarterly basis we are joined by officers from Elmbridge, Epsom & Ewell, Reigate & Banstead Borough Councils and Mole Valley District Council. The meetings are co-chaired by the Area Director from Adult Social Care and the Chief Operating Officer from the CCG.

48. The LJCG supports the delivery of our strategic priorities and the aims of the BCF. They key areas we are focusing on include:-

- Developing Community Hubs – integrated multidisciplinary teams of health and social care staff
- Developing a Rapid Response Service – Discharge to Assess
- Community Medical Teams – Medical support for the integrated community services.
- Prevention – working with Public Health, districts and boroughs, and the voluntary sector

49. The LJCG has the joint oversight of the BCF plan across Surrey Downs. It reviews finance and performance of the services, contracts and grants within the BCF. These include grants for carers, protection of social care, telecare and telehealth. The group provides help to identify opportunities for improving joint working locally, and so improves outcomes for local people.

**Integration in Surrey Downs**

Developing Community Hubs – integrated multidisciplinary teams of health and social care staff.

50. The Community Hubs are being developed around the three GP Locality Networks in Surrey Downs (East Elmbridge; Epsom and Dorking). The service will provide proactive care, initially for people over 75 years and this will then be rolled out for those over 65 years and the wider population. The Hubs will be made up of staff from CSH Surrey (community health) and Adult Social Care who will be co-located. The first phase will be launched in September 2015 and will have shared performance indicators.

Community Medical Teams – Medical support for local residents and for integrated community services.

51. The Community Medical Teams have been launched; these are allocated to each of the GP Locality Networks in Surrey Downs and will be providing medical leadership for the Community Hubs, as well as support for the Rapid Response service.

Developing a Rapid Response Service – Discharge to Assess.

52. In conjunction, with Acute Hospital and Community Health partners, a discharge to assess model from Epsom Hospital has been initiated. The Hospital Social Care Team is integral to this model. Services delivering rapid response in the local area have been identified but they are not joined up and so by bringing these together a more coordinated rapid response service will be in operation from winter 2015 with shared performance indicators.

Prevention

53. Work is being progressed with Public Health, districts and boroughs and the voluntary sector. We have a working group, made up of the CCG, Adult Social Care, Public Health, Districts and Boroughs and the voluntary sector. This group's focus is on the local preventative agenda, and has identified initiatives to help with winter wellbeing as well as reviewing preventative services in the area so that they are aligned to public health profiles and local need.

**Surrey Heath LJCG**

54. Surrey Heath has a strong LJCG with representation from CCG commissioners, Adult Social Care commissioners, Public Health and district and borough councils. This meeting focuses on strategic priorities outlined in the BCF as well as the wider priorities for health and social care integration.

55. This year Surrey Heath was shortlisted for Vanguard status. Feedback from the national team highlighted that the plan submitted demonstrated that strong relationships has been built across partner organisations. There was also recognition that Surrey Heath were further ahead with the implementation of plans than many other applicants and that the plans showed clarity and ambition. Whilst full Vanguard status was not awarded we were nominated to be part of the 'fast follower' system, with support being offered from the Kings Fund.

**Integrated Care Teams**

56. The ambition - Integrated Care is a new way of supporting local people, their families and carers by bringing together the professionals involved in providing care for those with health or personal care needs who live at home.

57. In Surrey Heath there are three Integrated Care Teams:

- Team South - based at Ash Vale Health Centre
- Team Central - based at Park Road Surgery
- Team East - based at Lightwater Surgery

58. The ambition of the integrated care teams means that people will only have to tell their story once because there will be a single plan of care shared with all the organisations supporting them. People will have a named co-ordinator of care and they will have a joint assessment of care needs to avoid unnecessary duplication. The team works together to keep people at home and reduce the need for them to go into hospital.

59. To date, a CCG wide integrated care model across 90,000 population, encompassing 9 separate organisations and 9 GP Practices has been implemented.

60. Further progress includes:

- 2014/15 Surrey Heath CCG identified £3.0M recurrent funding to invest in community-based services
- 3 x Integrated Care Teams (ICTs) commencing delivery of 8 to 8 local community-based care
- Access to local Rapid Response Services and the Community Rehabilitation Team available 7 days a week
- A Single Point of Access for community health and social care referrals is available
- The Integrated Care Teams (ICT), Rapid Response Service, Community Rehabilitation Team and Single Point of Access (SPA) are co-located and hosted in four local GP Practices

- Once recruitment is complete 114 (102.57 WTE) clinical and professional staff will be based locally in the ICTs and SPA offering community based services across the population of Surrey Heath.

**Our vision for the end of 2015/16**

61. A radical shift (equivalent of 6 fewer admissions to Frimley Hospital per day) in the number of emergency admissions will have taken place compared to 2014/15. This will be achieved through:

    - Establishment of integrated community teams of health and social care staff working alongside general practice.
    - A strengthening of personal care plans (potentially including personal health budgets).
    - Improved responsiveness at “crisis” points.
    - Improved co-ordination of care and support will be reported by patients and their carers.

62. In addition, patients with long term conditions will be identified early and appropriately supported in the community by their GP working in partnership with consultant specialists. Thresholds for admission will increase following discussions and agreement between GPs and consultants as greater confidence in community services is developed

63. The LJCG is due to hold a conference with the local Voluntary Community and Faith Sector. This conference, called "Making It Real", is part of a partnership approach to understanding local demand, need and priorities and how we can develop really strong local resilience. It will also support the involvement of the whole community to be partners and contribute to promoting the health and wellbeing of all residents of Surrey Heath.

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**Sources/background papers:**

Annex 1 –Table to show BCF, and total CCG & SCC funding, by CCG area

Surrey Better Care Fund Plan

Annex 1

**CCG BCF Allocations**

| | Better Care Fund | | 2015/16 Total Funding | | | | 2014/15 Baseline |
|---|---|---|---|---|---|---|---|
| | Revenue Allocation | % of BCF | Whole CCG Funding | Estimated Surrey Allocation* | % of Surrey Allocation | % of Budget covering Surrey | |
| | £000 | | £000 | £000 | | | £000 |
| East Surrey | 9,397 | 14% | 188,761 | 188,761 | 14% | 100% | 182,623 |
| Guildford and Waverley | 11,230 | 17% | 233,940 | 226,303 | 17% | 97% | 226,440 |
| North West Surrey | 19,808 | 30% | 404,373 | 404,373 | 30% | 100% | 392,066 |
| Surrey Heath | 5,501 | 8% | 111,538 | 111,538 | 8% | 100% | 106,150 |
| Surrey Downs | 16,398 | 25% | 336,496 | 336,496 | 25% | 100% | 326,479 |
| Windsor, Ascot & Maidenhead | 549 | 1% | 153,748 | 11,008 | 1% | 7% | 146,475 |
| Northeast Hampshire and Farnham | 2,601 | 4% | 234,402 | 52,132 | 4% | 22% | 227,146 |
| | **65,484** | **100%** | **1,663,258** | **1,330,611** | **100%** | | **1,607,379** |

** Estimated based on proportion of residents in each CCG area that relate to Surrey*