Wellbeing and Health Scrutiny Board
7 January 2016

Better Care Fund Enabler Projects - Position Statement

Purpose of the report: Scrutiny of Services and Performance Management

This paper sets out the current position for the Better Care Fund enabler projects and their progress to date.

Introduction

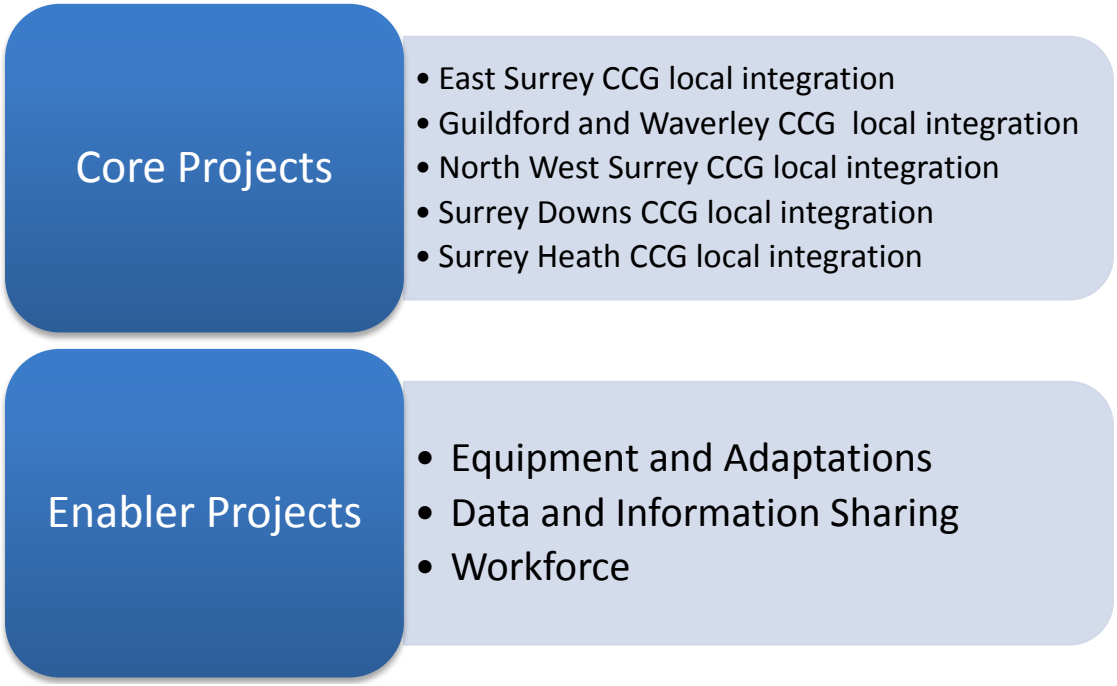
1. The Better Care Fund (BCF) is a national programme which creates a local single pooled budget to support and enable closer working between the NHS and local government. It is designed to:
   a. Improve outcomes for people.
   b. Drive closer integration between health and social care.
   c. Increase 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. In Surrey, the BCF involves pooling £71.4m of existing budgets in 2015/16, which will enable people to stay well, be supported at home where appropriate and enable people to return home sooner from hospital.

3. A 'local' approach has been taken to Surrey's BCF development - using six Local Joint Commissioning Groups (LJCGs) that have been established between Surrey County Council (SCC) and the Clinical Commissioning Groups (CCGs), plans are being developed that are appropriate for each local area based on local need. The models and degrees of integration are consequently varied and range between, for example, co-location, joint commissioning arrangements, one accountable organisation as a lead commissioner, pooled budgets and the creation of a separate integrated care organisation. Throughout these plans, there is commitment to achieving consistent, improved health and social care outcomes.

4. In addition to these local integration projects, there are three enabler projects that are designed to support and facilitate Surrey's local integration programme. The three enabler projects are; Equipment & Adaptations, Data & Information Sharing and Workforce.

5. Each enabler project focuses on a specific area of potential integration that can help achieve better outcomes for residents, whilst securing financial savings for health and social care public agencies through improved collaborative working. The diagram below shows the breakdown of core and enabler projects:



6. This paper outlines each enabler project's purpose, progress, plans for the future and its impact upon the wider determinants of health and tackling inequalities.

Equipment and Adaptations Enabler Project

Purpose

7. The Equipment and Adaptations Enabler was established to research and review how children, young people, adults with disabilities, older people and their carers in Surrey access and receive equipment and adaptations to help them live more independent lives at home. The equipment and adaptations services offered to residents include wheelchair services, the Community Equipment Service (CES) and handyperson services. The types of minor adaptations to homes include grab rails and ramps. The major adaptations include stair lifts, building adaptations and alterations funded through the Disabled Facilities Grants.

8. The project objectives are to achieve the following:

    a. Co-design a clear equipment and adaptations customer pathway.

    b. Develop a consistent set of equipment and adaptations service standards.

    c. Agree a consistent approach to commissioning equipment and adaptations.

Progress

9. At the start of the project it was agreed that the Equipment and Adaptations enabler would benefit from joint sponsorship. Health, Surrey County Council and District and Borough (D&B) councils each volunteered a sponsor to provide leadership for the project.

10. The project team completed comprehensive stakeholder research on the customer experience and the various funding streams for providing adaptations and equipment services in Surrey.

11. The findings identified that there is currently some good work and investment for equipment and adaptations in Surrey. Such as:

    a. Significant funding currently invested across the whole system, with over £15.5m per annum identified.

    b. Overwhelming support from Surrey County Council and D&B councils for getting independent advice and solutions.

    c. Evidence of collaborative working with a significant number of practitioners completing joint assessments with colleagues from other public sector organisations and private sector organisations.

12. The research also identified areas of inefficiency and confusion for residents. Key findings included:

    a. It was not possible to get an accurate understanding of the number or profile of children or adults assisted (the project team therefore focused on conducting primary research and gathering information).

    b. Customer satisfaction needs improving with over half of respondents to a Surrey residents survey saying they found it ‘hard’ or ‘very hard’ to access good quality information and advice about equipment and adaptations.

    c. More work needs to be done to join up protocols and the wide range of different pathways are difficult and confusing for customers to navigate.

13. The findings from the public and stakeholders informed the projects ‘I’ statements which provide a clear co-produced vision for the future of equipment and adaptations in Surrey.

14. In line with the 'I' statements a new model for delivery has been designed in partnership with representatives from Surrey County Council, D&B councils, CCGs, Surrey Coalition of Disabled People, Family Voice and Surrey residents.

15. The proposed model recommends the following design principles:

    a. Build on existing good practise

    b. Develop an integrated model.

        i. Integrate teams, agreed standards, processes and outcomes.

        ii. Introduce a named coordinator/navigator to support the customer through the whole process, from referral to installation and review.

    c. Acceptance of assessment to prevent delays.

    d. Include occupational therapist resource in the integrated service.

    e. Ensure housing options and occupational therapist advice is available at an early stage.

16. The findings and recommendations were reported to the Better Care Board in July 2015 and Surrey's Chief Executives in October 2015. Both endorsed the new proposed model and signed off their support for the project to commence the implementation phase.

17. At the Surrey Chief Executives meeting, each D&B council agreed to commit £1,000 to support the implementation of the project. Furthermore the Chief Executive of Reigate and Banstead Borough Council, John Jory, volunteered to join the project partnership board to contribute to the strategic oversight of the equipment and adaptations enabler.

Plans for the future

18. At a recent project group meeting it was agreed to take forward the implementation phase of the equipment and adaptations enabler project under the oversight of a programme board and to appoint a project manager.

19. At the start of 2016 we plan to host a Surrey launch event to consult on our implementation plans and establish a working group.

20. Develop the project implementation plans with the Local Joint Commissioning Groups.

21. The new CES contract has been procured (to ensure sustainable continuity of service after the end of the current contract on 31 March 2016. The Equipment and Adaptations Enabler input findings into the re-tender process. The new CES contract will need to interface with the Equipment and Adaptations Enabler. Work will be undertaken at the start of 2016 to ensure the contract aligns with the enabler's implementation plans, for its continued success.

Impacts on the wider determinants of health or tackling inequalities

22. The project enables people to remain independent and safe in their own home, with access to the support they need to make necessary adaptations to their home.

23. The project facilitates the shared ambition, for health and social care, of improving the outcomes for older people and younger people with disabilities, and ensuring they and their carers have excellent support.

24. Older people and people with disabilities and their carers are among the most disadvantaged in Surrey. Delivery of the equipment and adaptations enabler project will make it easier for residents to access reliable advice and information. As well as effective signposting into the services that can best support their needs.

25. The project supports our duty under the Care Act to facilitate access to impartial advice that is open to all, including those who may self-fund their equipment or adaptations, or the residents that are supported by discretionary funding from D&B councils.

26. The project increases the choices available to people and their carers and improves the likelihood that they can continue to live independently in their community. Without vital equipment and adaptations many individuals would no longer be able to remain in their homes and communities, preventing them from making decisions concerning their health and wellbeing.

Data and Information Sharing Enabler

Purpose

27. To build a platform that will allow data and communications regarding Surrey patients and residents to flow across professional, organisational and geographic boundaries of the Surrey health and care system, enabling Surrey to meet its integrated care and digital objectives over the next 5 years and beyond.

Progress

28. Commitment Statement: A health and social care commitment statement to share data and information has been ratified by Chief Executives on the Surrey Transformation Board and the Chief Executive's Forum (Districts and Boroughs).

29. Healthwatch Surrey Report: A report to capture Surrey public opinion on data sharing was commissioned and has been published. The report has been picked up by Dame Fiona Caldicott and the National Data Guardian's Panel. It will be referenced to support their work.

30. Surrey Information Sharing Protocol: The Surrey Information Governance Group (SIGG) has formed and is in the process of co-designing a Surrey Information Sharing Protocol with a view to going live in January.

31. Surrey Shared Electronic Care Record (SSECR) and Interoperability Portal: The CCGs and the Council have agreed to work collaboratively to drive this work forward.

Plans for the future

32. Surrey Shared Electronic Care Record (SSECR) and Interoperability Portal: Surrey officers have been instrumental in building the initial business case to gain traction for this project and our officers will form part of the Project Board going forward. Five CCGs are collaborating with health and social care providers across their footprint to deliver this solution. The lead CCG is North West Surrey. The ambition is as follows:

    a. Shared Care Record: Extracts data from all participating (health and social) care providers.

    b. Interoperability across systems: Care professionals access the record from within their primary/source systems (no extra log in).

    c. Real time data: Supports crisis management and multiple same-day interactions.

    d. Reporting and analytics: Will support iterative care planning, benefits tracking, identify service usage patterns, prioritisation of spend and commissioning plans.

    e. Bi-directional integration: Ensure accurate, timely and appropriate data capture in each participating care provider's system.

    f. Customer Relationship Management: Support contact management and scheduling.

33. The project is being implemented using a phased approach. The full vision is expected to be realised by 2018.

34. Common Consent to Share Model: This is a system-wide project the SIGG will be approached to develop. The desire is to agree a common approach and develop common communications. The expected completion is July 2016.

35. Surrey Digital Roadmap: Four CCGs have agreed to clust to develop a joint Digital Strategy across their combined footprint/geography. The work is being lead by the IT Director for the four CCGs. The Strategy or 'Roadmap' will outline plans to 2020 and beyond. Surrey officers are helping to build relationships with border partners to ensure interoperability doesn't end at our boundary. The first draft of strategy will be submitted to the National Information Board in April 2016.

36. Governance framework: Work is underway to establish an appropriate governance framework for the Digital Roadmap/Data and Information Sharing Programme. Surrey officers having volunteered themselves as a resource will attempt to move things forward at pace. The framework is expected to be functioning by April 2016.

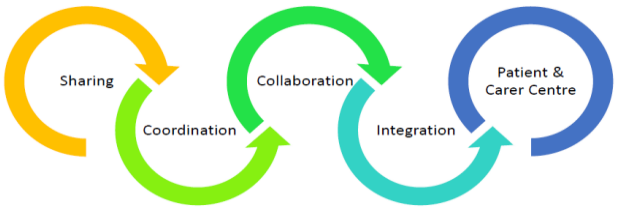
Impacts on the wider determinants of health or tackling inequalities

37. Patient/Citizen and Carers: The individual will only have to tell their story once. They will not have unnecessary tests and investigations. They will experience a 'holistic' care plan with seamless transitions and handovers that enable them to receive the care and support they need, in the place they want to receive it (their home and community) for longer.

38. Care Professional: The enabler will provide professionals with simple and common technologies that breed familiarity and are easier to adopt. They will spend less time on administrative tasks (chasing and writing up notes) and spend more time delivering health, care and support. They are able to stabilise their patients and citizens within their home, for longer, delaying the patient's need for hospitals and care homes. They will feel more satisfied in their roles.

39. Organisations: Will be able to understand the wants and needs of the local population and design new models of care to meet these. It will improve the quality, delivery and cost of service delivery. The project will help to increase the capacity to meet rising demands in a climate of reducing budgets. Health and social care staff will be more satisfied and staff turnover limited.

40. System: This enabler provides an opportunity to develop a Surrey whole systems approach to implementing initiatives (for example the SSECR) universally accepted as critical to transformation. It provides opportunities to access better economies of scale. It facilitates knowledge share and transfer. It is a catalyst for behaviour and culture change across organisations. It will support health and social care agencies to become fit for the future.



Workforce Enabler

Purpose

41. The workforce enabler group was established to provide the opportunity for health partners and SCC Area Directors to share integration intentions and progress, identify barriers to integration and shared opportunities. Where appropriate, the enabler group has also commissioned pieces of work to drive forward workforce development to support the integration agenda

Progress

42. The group have met to share plans and progress within each CCG locality and adopted a networked approach which includes an online network where partners have the opportunity to share resources and ideas.

43. Adult Social Care Area Directors have developed a set of overarching principles to providing a framework that underpins how the council will support and facilitate health and social care workforce integration in each area (see Appendix A). This will enable the Council to optimise limited resources to support workforce integration and provide confidence for the workforce in the way the integration agenda is progressed.

44. Due to differing contexts and local needs across the six CCG areas in Surrey, the speed and form of integration is not identical in each area. The following summary provides a high level update on progress in each area.

    a. **North East Hants & Farnham** are embarking on a fast track programme of work to bring together organisations responsible for planning and providing health and social care and to create a single plan and budget. Providers of health and social care are already working to integrate service delivery. A multi disciplinary team of health and social care professionals are meeting regularly to review and support the care planning of complex cases.

    b. **Surrey Heath** are aiming to create a single budget and management structure for the commissioning of care for older people and adults with long term conditions and/or complex needs with Surrey Heath CCG as the lead organisation. Three GP hubs have been created with integrated care teams encompassing Mental Health, Community Nursing and Social Care. The rapid response and reablement team are co-located.

    c. **East Surrey** is creating one commissioning team which is being progressed initially through joint commissioner meetings. There is a proposal to develop an integrated reablement unit at Surrey and Sussex Hospital and to support the Acute Model changes. The East Surrey system will also integrate social care services

into primary/community care settings. This will enable residents to access these services outside of the hospital setting to avoid admission or speed up discharge.

d. **Guildford & Waverley** are developing five locality hubs across 21 GP practices and a Proactive Care Teams pilot, initially in East Waverley to respond to the needs of the individual and their carer, supporting them to remain within the community. A multi-disciplinary discharge team has been created at The Royal Surrey County Hospital which includes social care professionals to create an Integrated Care Assessment Service.

e. **North West Surrey** are developing three multidisciplinary teams of health and social care staff to support the creation of three community hubs in Woking (launching December 2015), Weybridge and Ashford. A pool of bank care staff to provide additional support has also been established to support winter pressures. Various structures have been developed to support transformation and integrated working – these include GP led Locality Network Boards, regular senior leaders meetings across partner organisations, Strategic Change Boards across all areas of transformation in the CCG area.

f. **Surrey Downs** have developed a joint local integration strategy to provide the framework for local integration. A GP led unit at Epsom Hospital, Community Assessment Unit (CADU) has been launched supported by Epsom Hospital, social care and Central Surrey Health (CSH) staff, to provide same day diagnostic and integrated support to return home, where required. A community hub has been established with staff from CSH Surrey and Adult Social Care in East Elmbridge with planning underway for an Epsom service in the autumn and Dorking in the spring of 2016.

Impacts on the wider determinants of health or tackling inequalities

45. The driving ethos behind workforce integration is to improve resident experience and outcomes by supporting staff to share and develop new skills and ways of working. This will drive the creation of a multi skilled workforce that is able to meet a broader range of health and social care needs for individual residents. Multi skilled roles will be supported by the protection of specialist skills and knowledge that can be focussed to optimise their contribution to supporting residents with more complex needs.

Conclusions:

46. In the last year, the enabler projects have made good progress working across the complex Surrey health and social care system. The enabler projects will continue to have an important role to play in supporting and facilitating Surrey's local integration programme

Public Health Impacts

47. The impacts on the wider determinants of health or tackling inequalities have been summarised for each enabler project above.

Recommendations:

48. The Wellbeing and Health Scrutiny Board is invited to be aware of the progress of the three enabler projects - Data and Information Sharing, Workforce Development and Equipment and Adaptations

Next steps:

49. The three enabler projects will continue to progress their work across the Surrey health and social care system.

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Sources/background papers:

- Wellbeing and Health Scrutiny Board, 16 September 2015, Update from Surrey's Health and Wellbeing Board

Appendix A: Adult Social Care – A strategy for workforce integration

Adult Social Care - A strategy for workforce integration

SURREY

Adult Social Care Directorate strategy vision for 17/18

Work collaboratively with our partners to ensure people have choice and control, so they can maximise their wellbeing and independence in their local community and remain safe.

Delivering the vision

To realise the directorate vision and meet the demographic, policy reform and financial challenges ahead, we need a strategic shift in the way Adult Social Care delivers services and a refocus of available resources.

What will this look like?

- ✓ Joined up health and social care services centred around the individual, not organisational boundary.
- ✓ A shift from countywide models of delivery to local services designed to meet the needs of local people.
- ✓ Shared resources and skills to better meet individual needs.
- ✓ New models of delivery in collaboration with health and other partners.
- ✓ High quality, cost effective and sustainable services designed around people and local communities.

As a leadership team, we will share progress, knowledge and ideas with one another to ensure our local plans are consistent with these principles.

respect trust listen responsible

Local services designed for local people

We are committed to supporting each area with the freedom and flexibility to shape their health and social services around the local population. To enable this, we have agreed 6 core principles to provide a framework for workforce integration.

Behaviours	We will have individuals working in a variety of different models who all provide services to residents in a way that embodies the behaviours and values of the council.
Growing expertise	We will identify opportunities to enhance the skills of our staff to support the movement of skills and resources across health and social care disciplines
Workforce equity	We will review new and changed roles against our job evaluation framework to ensure work is rewarded appropriately and consistently.
Co-design	We will involve staff in the development of new ways of working and delivering our services.
Systems	We will work with partners to develop systems that support and enable integrated ways of working.
Flexibility	We will encourage the development of tailored ways of working and models of delivery that optimise the strengths and resources of each area.

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