EAST SURREY

Overview

This document provides a brief summary of the key elements of the East Surrey Better Care Fund Plan. The plan locally has evolved through the developing partnership and relationships in East Surrey, and the latest iteration reflects the significant amount of collaboration and co-design that has taken place over the last two years across the local health and social care economy.

Our focus continues to be on the strategic aims and programme objectives which are shared across Surrey:

- 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.

Since our last submission, the commissioning partnership with Adult Social Care in East Surrey has developed to the point of considering formal joint commissioning arrangements for a wider range of services. Detailed scoping work has begun and it is anticipated that we will be in a position to agree a longer term implementation plan during the early part of 2016/17. At a strategic level, a new post of Director of Integration has been jointly funded to work across the CCG and adult social care, demonstrating the broader commitment to integrated care locally. The post is now filled and a key priority will be to further develop the plan and systems relationships to enable the delivery of more coordinated care.

Engagement with providers across the East Surrey health and social care system is structured around the fortnightly Strategic Transformation Board, led jointly by the CCG, SASH and Surrey County Council, and bringing together acute, community, social care, primary care, mental health and ambulance services. All local strategic transformational developments are agreed through the Board. This process will be extended through the provider engagement and planning taking place around the Sustainability and Transformation Plan and associated place-based plan around the Surrey and Sussex Hospitals Trust local health and social care economy, as outlined in the Sussex and East Surrey approach to the STP submitted to NHS England in February 2016.

Due to the nature of the Strategic Transformation Board, which brings together the Chief Executives of the local organisations, there is already significant buy in from all parties. In addition, the parties have agreed to establish a Strategic Investment Fund that would allow the pump-priming of key transformational initiatives.

Our Public Engagement Strategy 2014-18 sets out our overall approach to public engagement, including engagement in the BCF and integration plans. Our main points of reference are the ESCCG Patient Reference Group, external community and health orientated groups, patient representation and feedback used when working on disease specific pathways. We have always been proactive in seeking out views and experiences of the local community, patients and carers, and especially of those less able

to speak for themselves and regularly meet with a number of local groups to achieve this. By going out to already existing groups, we can listen to our community in environments that are convenient and where people feel safe and confident to express their views and give feedback. These views and experiences are built into our commissioning intentions and plans for service changes and improvements.

Additionally, most of our GP member practices (16 out of 18) have a Patient Participation Group (PPG). The role of these groups is primarily to support the practice – giving thoughts ideas and opinions, helping with specific pieces of work that call for a patient perspective and acting as a communicator between the practice and their community. PPGs also represent their practice population through East Surrey CCG's Patient Reference Group.

The Patient Reference Group (constituted of nominated representatives from individual Practice Participation Groups, and, on occasions, extended to voluntary, community and faith sector organisations, support groups and individual representative patients) is integral to the work of the CCG and meets three times a year. The role of the Patient Reference Group (PRG) is to help the governing body of ESCCG make decisions about the services they commission and ensuring that these services meet the health needs of the local population.

Review of 2015/16

East Surrey's BCF plan for 2016/17 represents an evolution of the plans from 2015/16 and 2014/15, as we are part-way through our system transformation. Our plan for 2015/16 included three overarching schemes:

1. Reducing admissions and promoting swift and integrated discharge
2. Integrated multi-disciplinary team
3. Signposting and prevention

1. Reducing admissions and promoting swift and integrated discharge

A key element of the plan in 2015/16 was the development of a frailty unit on the acute hospital site. This unit has been developed and is due to open in April 2016. As a precursor, a Discharge to Assess model was developed operating from the A&E Clinical Decision Unit, incorporating integrated pathways to avoid acute admission with input from acute consultants, community services and social care.

Significant work was undertaken to develop the integrated multi-disciplinary discharge team at East Surrey Hospital, including the community, social care and acute discharge teams. Further work is required to achieve full integration and decision-making including a trusted assessor model.

Additional community rehabilitation beds were commissioned for people with complex needs, with community services and social care input to ensure people's rehabilitation potential was maximised. This resulted in a significant decrease in agreed continuing health care funded placements and packages of care, and led to the business case to establish the new Integrated Reablement Unit on the East Surrey Hospital site.

2. Integrated multi-disciplinary team

Systems for risk stratification in primary care and case management by Community Matrons are now in place across East Surrey. In four practices, this is supported by an extended MDT. Our plan for 2016/17 outlined below will build on this progress and embed good practice across the whole CCG area.

Shared electronic care plans have also been implemented across East Surrey, with access available to primary care, 111, out of hours, ambulance and community services professionals.

As indicated in the 2015/16 plan, community services staff have been re-aligned to localities in preparation for the new primary care networks, and the services have been re-specified to incorporate key elements of the BCF and integration plan.

3. Signposting and prevention

Following a successful six month pilot of a Wellbeing Prescription (social prescribing) service, a second phase expansion meant that by the end of 2015 all Tandridge practices had access to a dedicated Well Being Advisor. This scheme is funded through the BCF and involves the Wellbeing Advisor taking referrals from GPs and working with patients to identify and address their wider health and wellbeing needs.

During the pilot period the Wellbeing Advisor worked with over 130 people to address a range of issues including weight, physical activity, social isolation, transport, housing, depression, anxiety, smoking, finances and caring. People were referred to services including mental health support, emotion gyms, healthy walks, falls prevention, exercise on referral, volunteering, social groups and day centres. Over 78% of people who provided feedback said they would recommend the service to others and 11% said they had visited their GP less as a result.

The BCF funds a mental health Community Connections service in East Surrey. Provided by Richmond Fellowship, the service offers support and group work for people with mental health problems in the boroughs of Reigate and Banstead and Tandridge. The service aims to promote social inclusion, community participation, mental well-being and recovery by connecting people to mainstream activities in their community. Community connections services indirectly impact on emergency admissions by supporting people with mental health problems to remain well and recover. The service is also a key partner in the provision of a local safe haven for people experiencing a mental health crisis, or to prevent a mental health crisis (see below).

BCF funding also provides on-going support for voluntary sector welfare benefits advice.

Significant progress has also been made with improving the dementia diagnosis rate in primary care, which had improved to 63.1% at the end of February 2016. Further work is on-going to improve the diagnosis rate, along with work to improve post-diagnostic services and support.

Local action plan for 2016/17

Our plan for 2016/17 builds on the planning and implementation in previous years. The key initiatives are set out below under the headings defined by our strategic aims.

1. Enabling people to stay well

Through the BCF, the CCG and adult social care continue to invest locally in prevention with Tandridge District Council and Reigate and Banstead Borough Council, including expansion of the successful Wellbeing Prescription service. From January 2016 the Wellbeing Prescription service will also deliver a

Tier 2 Weight Management Programme in partnership with Tandridge Trust Leisure & Culture. The programme, which is funded by Surrey Public Health, will provide free 12 week weight loss courses which include education and exercise sessions plus free membership to Tandridge Trust facilities. All referrals will be through the Wellbeing Prescription service so that a more holistic approach we can provided by working with patients to address any wider health and wellbeing issues.

Reigate and Banstead Borough Council have recently recruited their own Wellbeing Advisor and three East Surrey practices have agreed to start work on the next pilot from April 2016.

Our support for local voluntary sector prevention schemes will continue, and we plan to increase involvement of the voluntary sector in supporting our transformation, prevention and independence agenda during 2016/17.

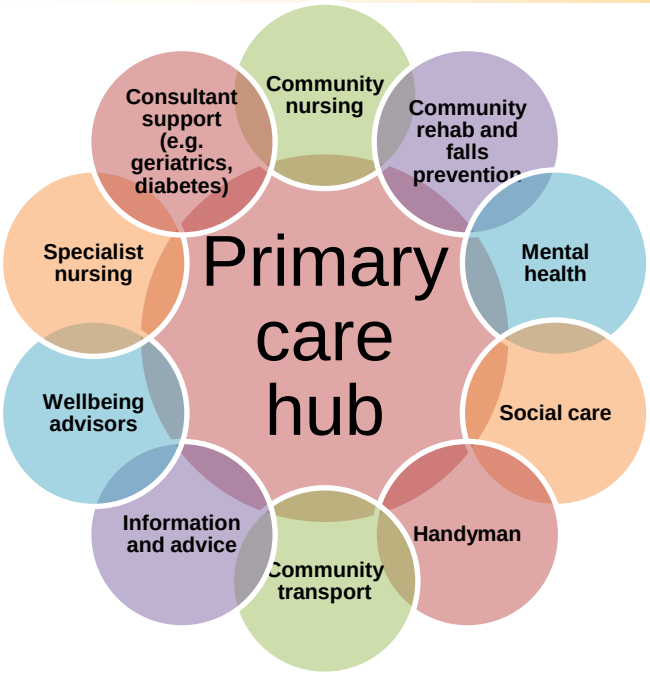
Additional investment from the BCF also continues to support the Community Equipment Service, which plays a key role in ensuring that people with low level needs are able to access equipment quickly to help them to stay at home.

2. Enabling people to stay at home

Significant investment through the BCF continues to support social care reablement services, telecare, telehealth and community health services, seven days a week. Services are working increasingly in a more coordinated way to keep people out of hospital. East Surrey's approach to risk stratification and multi-disciplinary working around complex case management remains as set out in previous plans. Practice has developed significantly and a clear impact on non-elective admissions can be seen in some areas.

The challenge for 2016/17 is to embed this way of working across all practices and demonstrate a significant impact on avoidable admissions. Our plans to achieve this are set out in East Surrey CCG's Operating Plan and include the development of primary care networks, with practices working together at scale across a larger footprint in a hub and spoke model. Further investment in primary care will enable a more proactive approach to managing population health and will deliver better outcomes. Integration of wider services around the hubs will include social care, community health, mental health and voluntary sector services. The objective is to localise care, and improve responsiveness and management of patients with complex needs and long term conditions. As part of this plan we will also pursue a consistent increase in opening hours, as a means of increasing the proactivity of primary care in meeting urgent and unscheduled needs of patients and users.

The diagram below shows the kinds of services that will be wrapped around each hub. Further work will be undertaken during 2016/17 to re-commission community services as wrap-around services for the emerging GP networks.



Plans to integrate mental and physical health services are being developed as part of this approach. This will include the development of primary care mental health services designed to improve low level support and secondary prevention, reducing reliance on secondary care services.

We expect to agree the structure and membership of each network during the early part of 2016/17, moving on to develop the commissioning and integration of wrap-around services in the second half of the year.

Work on two further schemes with primary care and community services are also designed to reduce avoidable admissions. A single, coordinated support service is being developed for nursing and residential care homes. This will involve enhancing medical and specialist nursing support to reduce conveyances and admissions from care settings. During 2016/17 we will also work on the falls and fractures pathway to improve proactive follow-up in the community, with the objective of reducing the number of repeat falls and fractures.

The CCG is also in the process of developing its dementia strategy including plans for improving post-diagnostic support. This will be key to ensuring people with dementia and their carers are supported effectively in the community and do not access hospital services inappropriately for their care.

We will continue to provide carers support and carers services. We are also reviewing our voluntary sector community support post-stroke and following hospital discharge, with potential to increase investment in this area.

3. Enabling people to return home sooner from hospital

BCF investment continues to support services designed to expedite hospital discharge, including social care teams for people requiring longer term support, social care reablement services, community health services working at the interface with the acute hospital, and the Red Cross “Home from Hospital” service for people who might be vulnerable to readmission without short-term practical support. Community beds at Caterham Dene and spot-purchased in local nursing homes continue to provide vital

capacity to enable people who need longer-term recovery to return home, rather than be permanently placed in residential and nursing care.

Key elements of the CCG's plan for 2016/17, as set out in the Operating Plan, include the following developments designed to prevent unnecessary non-elective admissions and support timely discharge of patients from acute settings.

A key priority for the early part of 2016/17 is the further development of the Integrated Reablement Unit at East Surrey Hospital. This is a new integrated service bringing together hospital, social care and community services, to discharge patients into a 22 bed reablement unit on the SASH site, to support improvement in function, facilitate discharge and reduce dependency post-acute discharge. The service has been up and running since January 2016 with a review point in April 2016. Plans for 2016/17 include the procurement of a long-term provider for the unit and further development of the reablement model including voluntary sector, social care and community services providers.

The new Frail Elderly Unit at East Surrey Hospital was part of our BCF in 2015/16 and is due to open in April/May 2016. This is a new service designed to divert elderly frail patients from A&E into a dedicated non-bedded unit within the hospital for assessment, diagnosis, observation and triage to further treatment. This is a joint initiative between the hospital, social care and community health services. Work in 2016/17 will include embedding of pathways and development of relationships and joint working between the multi-disciplinary team working on the unit.

The Redhill Mental Health Safe Haven, funded through Crisis Care Concordat funding, is designed to support people in mental health distress and avert crisis, preventing avoidable acute admissions. The unit opens in late March and is a collaboration between the CCG, voluntary sector, social care and secondary mental health services.

The adult Psychiatric Liaison Service at East Surrey Hospital is funded by East Surrey CCG, Crawley CCG and SaSH. The current service is commissioned to provide a 24 hour service seven days a week. The day service is a core funded service with the enhanced overnight provision funded through non-recurrent funding streams. The 24 hour enhanced provision has supported a reduction in hospital attendances achieved through targeted intervention for people with a mental health condition who attend ED frequently. The main challenge is in achieving sustained investment for the enhanced hours and the 2017/18 collaborative commissioning intentions will be to commission the Core 24 Psychiatric Liaison Service Specification.

DELIVERING 7 DAY SERVICES

East Surrey CCG's Operating Plan for 2016/17 sets out the overall approach to delivery of seven day services designed to prevent unnecessary non-elective admissions and support timely discharge of patients from acute settings.

Social care and community health services already work across the system seven days a week, coordinating services to keep people out of hospital and to return them home as quickly as possibly following an acute admission.

Key elements of the CCG's plan for 2016/17, as set out in the Operating Plan, include the following developments:

- Strengthening our primary care delivery system, including the development of networks of practices designed to deliver primary care services at scale to proactively manage the health of the local population.
- Development of hubs central to the network which bring together community health, social care, mental health and voluntary service provision to localise care, and improve responsiveness and management of patients with complex needs and long term conditions.
- Recommissioning of community services as wrap-around services for the emerging GP networks.
- Further development of the Integrated Reablement Unit at East Surrey Hospital. This is a new integrated service bringing together hospital, social care and community services, to discharge patients into a 22 bed reablement unit on the SASH site, to support improvement in function, facilitate discharge and reduce dependency post-acute discharge. The service has been up and running since January 2016 with a review point in April 2016. Plans for 2016/17 include the procurement of a long-term provider for the unit and further development of the reablement model including voluntary sector, social care and community services providers.
- Development of an Elderly Frail Unit at East Surrey Hospital. This is a new service designed to divert elderly frail patients from A&E into a dedicated non-bedded unit within the hospital for assessment, diagnosis, observation and triage to further treatment. This is a joint initiative between the hospital, social care and community health services and is due to go live in April 2016. Work in 2016/17 will include embedding of pathways and development of relationships and joint working between the multi-disciplinary team working on the unit.
- The Redhill Mental Health Safe Haven, designed to support people in mental health distress and avert crisis, preventing avoidable acute admissions. The unit opens in late March and is a collaboration between the CCG, voluntary sector, social care and secondary mental health services.
- Increased involvement of the voluntary sector in supporting our transformation, prevention and independence agenda.
- Development of a single, coordinated support service for nursing and residential care homes with enhanced medical and specialist nursing support, to reduce conveyances and admissions from care settings.
- Development of the falls and fractures pathway to improve follow-up in the community and reduce the number of repeat falls and fractures.
- Continuing to commission 24 hour psychiatric liaison services at East Surrey Hospital in conjunction with Crawley CCG and SASH.

More broadly, investment through the BCF continues to support timely discharge through building or maintaining capacity in community health services, social care and the voluntary sector. In particular, BCF investment is supporting:

- Maintenance of social care hospital staffing.
- Maintenance of social care reablement staffing supporting discharge from hospital.
- Capacity in community health services, including spot-purchased community beds.

Voluntary sector “Home from Hospital” service, designed to support non-complex discharges with short-term practical support for people who might otherwise be vulnerable to readmission.

JOINT APPROACH TO ASSESSMENT AND CARE PLANNING

East Surrey's approach to risk stratification and multi-disciplinary working around complex case management remains as set out in previous plans. Practice has developed significantly and a clear impact on non-elective admissions can be seen in some areas.

As part of the emerging health and social care hubs, we are strengthening joint working and pursuing a clear and time-bound integration agenda across our providers, including health, social care and the voluntary sector.

The challenge for 2016/17 is to embed this way of working across all practices and demonstrate a significant impact on avoidable admissions. The CCG's plans are to achieve this through the development of primary care networks, with practices working together at scale across a larger footprint. Further investment in primary care will enable a more proactive approach to managing population health and will deliver better outcomes. Integration of wider services around the hubs will include social care, community health, mental health and voluntary sector services. The objective is to localise care, and improve responsiveness and management of patients with complex needs and long term conditions. As part of this plan we will also pursue a consistent increase in opening hours, as a means of increasing the proactivity of primary care in meeting urgent and unscheduled needs of patients and users.

The CCG is also in the process of developing its dementia strategy including plans for improving post-diagnostic support. This will be key to ensuring people with dementia and their carers are supported effectively in the community and do not access hospital services inappropriately for their care.

CONSEQUENTIAL IMPACT ON PROVIDERS

Engagement with providers across the East Surrey health and social care system is structured around the fortnightly Strategic Transformation Board, led by the CCG and bringing together acute, community, social care, mental health and ambulance services. The developments outlined above around the acute hospital setting (Integrated Reablement Unit and Frail Elderly Unit) have been agreed through the Board. The impact of the schemes is discussed and agreed with all providers and there is a clear focus on reducing non-elective admissions and delayed transfers of care.

At an operational level, the new services are being co-designed with acute clinicians, primary care, therapies, social care and community services. The impact on the workforce of each development is considered and negotiated as part of this process.

Through the annual contract negotiation process, the CCG is agreeing the acute activity with Surrey and Sussex Hospitals Trust with the objective of a single, agreed activity plan. The contract envelope and investment in community health services will be agreed through the contract negotiation process with First Community Health and Care.

This process will be extended through the provider engagement and planning taking place around the Sustainability and Transformation Plan and associated place based plan around the Surrey and Sussex Hospitals Trust local health and social care economy, as outlined in the Sussex and East Surrey approach to the STP submitted in February 2016.

Due to the nature of the Strategic Transformation Board, which brings together the Chief Executives of the local organisations, there is already significant buy in from all parties. In addition, the parties have agreed to establish a Strategic Investment Fund that would allow the pump-priming of key transformational initiatives.

Our Public Engagement Strategy 2014-18 sets out our overall approach to public engagement, including engagement in the BCF and integration plans. Our main points of reference are the ESCCG Patient Reference Group, external community and health orientated groups, patient representation and feedback used when working on disease specific pathways. We have always been proactive in seeking out views and experiences of the local community, patients and carers, and especially of those less able to speak for themselves and regularly meet with a number of local groups to achieve this. By going out to already existing groups, we can listen to our community in environments that are convenient and where people feel safe and confident to express their views and give feedback. These views and experiences are built into our commissioning intentions and plans for service changes and improvements.

Plans to integrate mental and physical health services are being developed as part of the wider strategy to develop integrated services that wrap-around the new primary care networks, as discussed above. This will include the development of primary care mental health services designed to improve low level support and secondary prevention, reducing reliance on secondary care services.

ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE – LOCAL SUMMARY

Current actions / services in place:

- Social care seven day services within the acute setting, maintained with BCF funding
- Community health services seven day working within both acute and community settings, maintained with BCF funding
- Strong systems, processes and working relationships between the partners based around the SASH health economy
- Existing schemes funded or maintained through the BCF, including
    - Step up/Rapid Response at Caterham Dene
    - Discharge to Assess scheme in A&E (Clinical Decision Unit), as a precursor to the Frail Elderly Unit
    - Rapid response and reablement services managing the acute to community interface
    - Red Cross Home from Hospital services
    - Telecare
    - Integrated Multi-Disciplinary Discharge Team working at SASH – co-located and integrated community, social care and acute discharge team
- Existing schemes funded by investment sitting outside the BCF, including:
    - Spot-purchased community and care beds to flex capacity up and down as needed

New schemes:

- Integrated Reablement Unit
- Frail Elderly Unit
- Primary care networks and integrated hubs
- Enhanced care in nursing and residential care homes
- Falls and fractures pathway

GUILDFORD & WAVERLEY

DELIVERING 7 DAY SERVICES

Guildford and Waverley CCG's Operating Plan for 2016/17 sets out the overall approach to delivery of urgent care services designed to prevent unnecessary non-elective admissions and facilitate discharge of patients from acute and community hospital settings.

The care and health community work in partnership across to align and integrated service provision that will support people to remain in their normal place of residence or to return as quickly as possible.

The delivery objective is to further develop an accountable integrated urgent care community that is responsive to patients and carers in crisis and delivers care in the most appropriate way. The CCG is working with its local system resilience group and urgent care networks to implement the 8 high impact actions for resilience planning. Working with partners as part of the urgent and emergency care network working towards implementation of new models of emergency care delivery and will use CQUINs to implement the findings of the urgent and emergency care review.

The following schemes make up the Unplanned Care Programme that will contribute:

Unplanned Care
Care Home Nursing and Primary Care Services
A & E Triage Service
Ambulatory care pathway
Ambulance 75% Target
Mental Health/Frequent Attenders Service
Hydration in Care Homes Service
ICP – Defined local pathways for Long Term Conditions
CHC Project
Falls Pathway
Community Single Point of Access
Frailty Initiative

Supporting the system to reduce A&E attendances within our local acute provider (Royal Surrey County Hospital NHS Trust (RSCH)) through:

- Whole system focus on pathways of care through the System Resilience Group and the Better Care Fund Local Joint Commissioning Group;
- Commissioning the Primary Care based Frailty Initiative that supports frail older people in their local community and high quality proactive anticipatory care planning that is used by the emergency services; this has significantly reduced unnecessary ambulance conveyances;
- Improving discharge pathways and significantly reducing excess bed days.

In parallel with our aspiration to reduce acute hospital activity, we will develop systems that facilitate better use of care homes beds which will be supported by primary care and community health service provision. We will review the community hospital bed capacity and establish pathways for community and nursing home 'step up' beds, for patients who do not need the intensity of an acute hospital, and as 'step down', for use when the patient is medically fit for discharge from the hospital setting.

The CCG is working collaboratively with the acute, community and social care providers and the System Resilience Group to help improve the flow of patients through the A&E department. In particular this is focused around improving the ambulatory care pathway and other subsidiary areas identified in the NHS ECIST specific work plan that has been identified with RSCH.

Improving care for patients in care homes by commissioning targeted support to community care homes, focusing on medication reviews, end of life care planning and treating, where appropriate, patients outside of acute care settings. The CCG continues to focus on delivering care closer to home and is working with partners to develop a whole system population based service model. My Care, My Choice integrated strategic partnership ensures that the unplanned care schemes in the CCG are tailored towards building resilience into the system to ensure that the population continues to receive appropriate care, in the right setting, irrespective of changing demographics.

By developing services that are designed to support patients back into the community, when clinically indicated, supported by a robust needs-based care package, we aspire to reduce the demand on the A&E department, and in turn reduce the time that patients will have to wait for urgent care services. Additionally, the CCG will continue to develop outwardly facing communications that will help to support the community to make better choices about how they choose to access health care services. This will empower our residents to manage their own health, and make the right choices about accessing urgent care services when it is appropriate to do so.

The CCG will build upon existing relationships with the ambulance service provider to ensure that ambulance performance improves, and that urgent response times for patients meet the national targets. By continuing to promote the NHS 111 service, and commissioning a more comprehensive service model for NHS 111, this should help to reduce the demand on 999 urgent care responses, and in turn improve ambulance services performance. Additionally, by continuing to invest in integrated community care, and in supporting care homes more proactively, there should be a significant impact upon 999 activity levels.

The recently implemented 'immediate handover policy' between ambulance and A&E colleagues should significantly reduce the ambulance handover times being experienced in the Trust. As a result, there should be more resource available to respond to urgent care 999 demand.

With regards to mental health, the CCG will continue to support those patients experiencing a crisis in their mental health by extending the psychiatric liaison service to a 24/7 model. This will ensure a rapid response, irrespective of time of presentation, for those vulnerable individuals requiring dedicated mental health input and will ensure that they receive the care they need in the most appropriate care environment.

We will work with all stakeholders across the system to ensure that the needs of people with mental illness in crisis are responded to in line with people with physical health needs. We have developed a 24/7 Psychiatric Liaison Service at RSCH that ensures patients with mental illness, attending A&E or

admitted, receive the physical and mental healthcare that meets their needs. We will continue to review and develop the pathways of care and support frequent attenders to the hospital through providing access to statutory and voluntary health and care support services, making reasonable adjustments as required.

To support the system to achieve the performance targets we have:

- Built upon the cross-system relationships through strengthening the System Resilience Group
- Commissioned and actively promoted a comprehensive service model for NHS 111
- Commissioned a HALO system to reduce wasted ambulance handover time

We will continue to improve the system through implementation of the following milestones:

Critical Milestones	Timescale
Invest in integrated community care, and support care homes, through developing a locally commissioned care home service	September 2016
Performance manage the SeCAMB immediate handover policy to ensure that ambulance handover times are being reduced	April 2016
Support patients who have mental health crisis through the provision of the Safe Haven Café in Guildford	June 2016
Redesign of the 24/7 psychiatric liaison service, where CPNs are based in A&E and included as part of the A&E staffing establishment	September 2016
Completion and ratification of a Falls strategy	April 2016
Commission new whole system Falls pathway	September 2016
Surrey wide stroke service commissioned	September 2016
Diabetes prevention plan – first wave	April 2016

JOINT APPROACH TO ASSESSMENTS AND CARE PLANNING

The Integrated Care Partnership, now known as, 'My care, my choice' (MCMC) is Guildford and Waverley's local health and social care system's integration programme which is to support frail older people in the community. The model of care is based upon the needs of frail older adults for two reasons:

- Frail older adults account for high volume use of social care, acute and community health services;
- Frail older adults are more likely to have complex needs and the system redesign will support them in regaining or retaining independence in their local community;

MCMC's vision is to have more intensive management of the frail older over time with more resources focused on supporting this group of patients in the community and preventing acute hospital admission. Currently the patient and carer experience of services is confusing and disjointed resulting in a poor experience. MCMC will bring together services in a more streamlined manner, and improve experience for patients and carers, and allow for easier navigation for professionals working with the frail and older population.

Principles

The main principles for the integrated care model, 'My care, my choice', are:

- To ensure that patients and those with caring responsibilities have access to the right service at the right time in the right place;
- That all agencies and organisations work collectively to deliver holistic care that meets the needs of the frail older population and their carers;
- To ensure services are centred around the needs of patients and their carers so that care is coordinated and integrated with care planning centred around need;
- To reduce demand through identifying and supporting patients and their carers to access prevention and early intervention initiatives;
- That there is a culture where staff from all organisations are enabled to work alongside each other to share responsibility for patient outcomes;
- That the voluntary sector is central within the development of integrated care and care pathways.

During 2015/16 we have increased the Dementia diagnosis rate from 44% to just under 60%. We recognise that there is more to do; we have identified resources to deliver additional services into Care Homes and Primary Care in order to improve the early identification of dementia.

The Guildford and Waverley Dementia Strategy Delivery Plan will create a universal, consistent offer, including:

- Developing carer support services to reduce geographical inequalities in access to services
- Increasing rates of timely diagnosis
- Developing a clear pathway for patients diagnosed with dementia
- Training professional dementia carers to recognise and act on signs of deterioration
- Developing services to support frail elderly patients in residential care
- Creating 'dementia friendly hospitals' and communities

Dementia Programme Key Deliverables		
	Review and redesign existing care pathways to fit the new service design	September 2016
2.	Support primary care in early diagnosis	December 2016
3.	Ensure there are appropriate services in place to support people with early onset dementia and their carers	July 2016
4.	Ensure staff and carers have the training to address the needs of people with dementia and mental illness	July 2016
5.	Ensure carers can access training to address the needs of people with dementia and mental illness	September 2016
6.	Increase access to support and advice for carers of people with dementia or older people with mental health problems	July 2016

Risk stratification, person identification and locality multi-disciplinary team meetings:

Risk assessment is done at a local level / GP practice with MDT with a focus on those over 75 years old with 3 or more conditions.

The Proactive care team will work with the GP practices and Frailty Initiative to identify patients at risk of deterioration and acute admission. Once patients have been identified they will be flagged as requiring case management by the Proactive Care Team.

GP carries out the following:

- Risk stratification of 'at risk' patients
- Physical examinations
- Development of care plans with patients, carers
- Early warning signs, investigate and diagnose exacerbations of illness and arrange for treatment to be implemented
- PACE care planning and ensuring care plans are developed for those individuals identified as being at risk
- Review of daily/weekly admission and attendance reports;
- Follow up of patients admitted to support timely discharge
- Regular visits to patients at risk, in their normal place of residence

Locality Multi-disciplinary Team (MDT) Meetings

Patients can be referred to the locality MDT if they have proven too complex and challenging for the local VW. GPs will meet monthly with Proactive Care Team to discuss these challenges and to agree next steps in care. Risk stratification tools, clinical experience and data on patient episodes of care are used to identify patients for the MDT discussion, and criteria include:

- Hospital admissions
- Frequent A&E attendances
- Long Term Conditions
- Multi-agency input
- High packages of care

CONSEQUENTIAL IMPACT ON PROVIDERS

Engagement with providers across the Guildford and Waverley health and care community is structured around the Integrated Care Partnership Steering Group, led by the CCG which brings together acute, community, social care, mental health and ambulance services.

The opportunity to procure the Community Health Services has provided a catalyst to review the current service provision and to establish a new commissioned integrated health system that will be ready to integrate further with care service provision as we move into the transformational period of the contract award.

The 'to be' service specifications have been co-designed with acute clinicians, primary care, therapies, social care and community services. The intention is to shift as much activity into out of hospital setting where possible and the innovative procurement and contract model will enable us to collectively incrementally build our integrated provision that will be able to shift resources flexibly to the places where demand exists.

This process will be extended through the engagement and planning taking place around the Sustainability and Transformation Plan and associated place based plan around the Surrey and Sussex Hospitals Trust local health and social care community, as outlined in the Surrey Heartlands approach to the STP currently under development.

Due to the nature of the Strategic Transformation Board, which brings together the Chief Executives of the local organisations, there is already significant buy in from all parties. In addition, the parties have agreed to establish a Strategic Investment Fund that would allow the pump-priming of key transformational initiatives.

We are working closely and collaboratively with our partners in Public Health and Surrey County Council to use public health data to inform and develop the local Joint Specific Needs Assessment (JSNA) report. This includes important data on local prevalence and morbidity around mental ill-health within the local community. GWCCG is an active participant in our local Health & Wellbeing Board where mental health commissioning and provision is a standing agenda item. GWCCG actively prioritises mental health promotion, and raising mental health awareness, among the local workforce through comprehensive training initiatives across primary care, acute hospitals and ambulance staff. We are working with all our GP Practices to support our priorities of early detection of mental disorder and the development of a clear pathway to appropriate treatment through Improving Access to Psychological Therapies (IAPT).

ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE – LOCAL SUMMARY

Current focus and strengthening of the System Resilience Group where all providers work to ensure that the health and care community are able to meet the variable levels of demand experienced in the system.

Hospital Improvement Group (HIG) Working Groups established and will develop clear and definable action plans against a set of agreed definable objectives that work to improve length of stay and reduce Delayed Transfers of Care.

The System Resilience and HIG working groups will ensure that clear lines of responsibility, accountabilities, and measures of assurance and monitoring review the following:

- NHS High Impact Interventions for Urgent and Emergency Care
- Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC
- Develop whole patient pathways that support improved patient flow
- Review and ensure occupancy and productivity of community hospital beds and intermediate care provision is achieved

- Existing schemes funded or maintained through the BCF, including
    - Discharge to Assess scheme
    - Rapid response and reablement services managing the acute to community interface
    - Red Cross Home from Hospital services
    - Telecare
    - Primary Care Virtual wards
    - 24/7 Psychiatric liaison services
    - Interface Geriatricians

- Existing schemes funded by investment sitting outside the BCF, including:
    - Frailty Initiative
    - Secamb Halo – reducing wasted ambulance time
    - Acute In Reach nursing
    - Enhanced Community Nursing

  - Enhanced Rapid Response
  - 24/7 Psychiatric liaison services
  - Age UK Independence project
  - Locality engagement with VCS

New schemes:

- Additional Nursing home beds
- Ambulatory Care pathway
- Rapid Assessment and Treatment Service
- Acute Integrated Care and Discharge Service
- Falls Response Service
- Acute Frail Elderly Unit
- Integrated locality hubs
- Enhanced Community Nursing care in nursing and residential care homes
- Rehydration project in Care Homes

NORTH EAST HAMPSHIRE & FARNHAM

Integrated care in North East Hampshire and Farnham is underpinned by our Primary and Acute Care System Vanguard.

Our Better Care Fund plans for both North East Hampshire with Hampshire County Council and Farnham with Surrey County Council are aligned with the delivery of our Vanguard model of care.

The Better Care Fund seeks to support the delivery of these existing plans with the investment aligning to priority areas of joint working in our new model of care.

The Vanguard is a whole system approach, equally owned by all partner organisations and local communities. We are developing a population health management considering the needs of our whole population and all of the assets that we have locally.

The North East Hampshire and Farnham Vanguard Programme was launched in March 2015 to accelerate our work to introduce a new model of care, co-designed with local people, that results in better health and wellbeing for residents and better value for money for health and social care services.

Our aim is to support local people to be happier, healthier, and where possible to receive more care at home.

The new model of care will address the three 'gaps' identified in the Five Year Forward View – the *health and wellbeing gap*, the *care and quality gap* and the *financial gap* – and is intended to be replicable across the NHS.

We have made significant achievements in the last 10 months. We have:

- made a step change in emphasis in prevention and self-care, with investment in social prescribing, in education and support for people with mental health and long term conditions, in enabling pharmacies to play a greater role in health promotion, and in supporting carers
- strengthened services in our communities to enable more people to be cared for at home. By investing in primary and community care we are supporting General Practice to work at scale, and enabling primary, community, mental health and social care services to work together to identify and proactively manage those individuals who are at greatest risk. Integrated care teams are established in each of our 5 locality areas.
- begun to break down the barriers between hospital and out-of-hospital care, with GPs working in Frimley Park Hospital, hospital consultants supporting locality based care, and previously separate teams from acute, community and social care working as one to avoid admissions and minimise delays in hospital
- invested in technology to improve access for clinicians to care records – aiming to create a fully intra-operable record that can also be accessed by patients.
- Begun to change the way we work with local people to co-design services, with a new cadre of Community Ambassadors – 47 individuals who are directly involved in our programme and are being developed and supported to confidently and effectively work with us to lead change – and a strong mandate to change from local people.

Our vision of our model of care is made up of 5 core component parts.

1) Strengthening focus on self care and prevention
2) Enhancing primary care
3) Introducing multi-disciplinary locality teams
4) Improve local access to specialist expertise and care
5) Creating a shared care record

We have made sound progress and now have ambitious plans for delivery during 2016/17. The Better Care Fund will specifically support the achievement of 1) and 3) above – strengthening self care and prevention and our multi-disciplinary locality teams.

We will measure our success around our aims for our population to be happier, healthier and at home with better value for money through the following whole system outcomes:

Local people are happier (improved wellbeing and experience)

a) Improved personal wellbeing of the North-East Hampshire and Farnham population
b) Increased confidence of local people to take responsibility for their own health and wellbeing
c) Increased proportion of people having a positive experience of care

Local people are healthier

d) Improved mental and physical health outcomes for the population of North-East Hampshire and Farnham.

Local people receive more care at home or in the community

e) Reduced amount of time people spend avoidably in hospital: reducing the rate of admission to hospital, eliminating delayed transfers of care, and eradicating waits in hospital for assessment or for decisions about ongoing care needs
f) Reduced intensity of packages of social care support, and reduced rate of permanent admissions to residential/nursing care homes

Better value for money

g) Reduce overall health and social care costs, per head of population, so that future demand can be met within the available resources

Sustainable Workforce

h) Improved staff satisfaction for the health and social care workforce, which will in turn result in improved care for individuals

Model of Care 2016/17 delivery plans

Our vision of our model of care is made up of 5 core component parts.

1) Strengthening focus on self care and prevention
2) Enhancing primary care
3) Introducing multi-disciplinary locality teams
4) Improve local access to specialist expertise and care
5) Creating a shared care record

The Better Care Fund supports all of our model of care, with a specific focus on 1), 2) and 3) above.

1) Self Care and Prevention: Supporting People to Stay Well

To promote wellbeing and build resilient communities, supporting individuals to maintain their own health, taking targeted action to prevent ill health and intervening earlier for those at risk of becoming unwell.

The Wellbeing Centre in Aldershot has been established, providing support and information focussed on emotional wellbeing and recovery, and includes the Safe Haven Crisis Café. Through the Vanguard Programme, existing CCG and system wide prevention and self care activities are being supplemented by testing four initiatives:

- Social Prescribing: Linking people to activities in their community and connecting people to other sources of support
- Healthy Living Pharmacies: Supporting pharmacies to reduce inequalities within the local community
- Recovery College: A series of educational interventions which focus on living with and living beyond a mental health or other LTCs
- Supporting Carers: Establishment of local carers' hubs and a carers' forum.

A social prescribing pilot is now underway in one of the five localities, pharmacy training has begun, testing is underway of the recovery college programme, with 80 people enrolled, and co-design of the carers hub model has commenced.

The key focus for 2016/7 is to complete the planned 18 month test of the four initiatives described above, and evaluate the impact. The key milestones are:

- Social prescribing service rolled out to all five localities by April 2016, including training of up to 600 staff in Making Every Contact Count
- Nine Healthy Living Pharmacies operational from July 2016
- Recovery College courses available from April 2016, with roll out of 20 courses by the end of 2016/7
- New Carers' hub model in place from June 2016
- Mid-point implementation review and evaluation in June 2016
- Full Evaluation of the model and decisions about whether to continue – March 2017

2) and 3) Enhanced primary care and Locality based integrated teams

a) To introduce a new model of enhanced primary care where practices work together and with other care professionals in localities to improve access to and to manage the workload in primary care
b) To use risk stratification tools to identify those individuals at greater risk
c) For professionals from primary care, community care, mental health and social care, and from the voluntary sector, to work together as a single team to deliver joined up health and social care for those individuals, in line with an agreed care plan

The key focus for 2016/7 is to introduce a new model of primary care with fully integrated working in all five localities by the end of 2016/7.

The key milestones are:

- Testing new model in Yateley locality from April 2016 and Aldershot from May 2016
- Base for Farnborough ICT in place by June 2016
- Evaluation of Farnham model begins June 2016
- First cohorts complete leadership and OD programme by June 2016
- All Integrated Care Team activity directly informed by risk stratification tools by July 2016
- All five localities testing aspects of the new care model by Sept 2016
- Full evaluation of the impact of new care models from October 2016
- Roll out of successful components of tested models from January 2017
- Discharge to assess roll-out
- Reablement joined up across care and health
- Increased use of telecare and telehealth
- Joined up assessment and market management across health and care for continuing health care

NATIONAL CONDITIONS

DELIVERING 7 DAY SERVICES

Our model of care as described earlier, is underpinned by the theme of 7 day working. Many of our services are already operating over 7 days per week including, the acute hospital, discharge teams within the hospital and out of hours primary care delivered by local GPs. Over 2016/17, we will build on this success to ensure that our integrated locality teams offer 7 day services to meet local need.

Throughout our model of care, we are considering the needs of our population within two large groups of our community. This does not mean that individual support planning and person centred services are not paramount in our model – taking this approach supports us to do strategic planning for our whole population. Firstly, we are considering the needs of the whole population when designing services and then secondly the needs of those people who may need more support, either for a short time or on a more ongoing basis.

JOINT APPROACH TO ASSESSMENTS AND CARE PLANNING

Our teams in our 5 localities have already started to jointly assess and support plan for individuals in our community. The work has been driven at the grass roots with local operational teams, clinicians, voluntary organisations and community ambassadors. The work has identified that the NHS and social care use assessments and care planning for different groups of the population at different times. During 2016/17 we will ensure that this work grows spanning reactive and proactive work which has traditionally taken place within community nursing, social care, continuing health care and general practice with the support of the voluntary sector and community ambassadors.

DATA SHARING

For North East Hampshire and Farnham CCG, the Hampshire footprint is important alongside the Surrey footprint. The work in Hampshire is well developed with good progress.

In Hampshire - all health services use the NHS number as the primary identifier in correspondence. 98% of current Social Services cases have the NHS number identified. The use of the NHS number is facilitating linkage of health and social care information through the Hampshire Health Record Data

Repository. The social care data feed is now live allowing access to information about involvements, care plan and significant “other” with health services sharing allergies, medications and diagnosis. Compliance with Information Governance standards is confirmed.

We are committed to adopting systems based upon Open APIs and Open Standards.

Further we are developing the Hampshire Health Record (2) to strengthen our approach which together with the wider digital strategy will enable the whole system of health and social care overview to occur via system wide interoperability supported by an overarching information sharing protocol amongst commissioners and providers of health and care services, underpinned by specific local operational agreements.

Although Hampshire and Farnham is in the unique position of having a Hampshire Health Record data repository as a foundation for a shared approach we recognise that we need to use the opportunities of technology in supporting multi-disciplinary practice more creatively. The John Hopkins Adjusted Clinical Groups (ACG) algorithms tool has been used to stratify risk and support development of care plans. GPs continue to review the top 1% of their most at risk population each quarter, implementing an agreed care plan identified patients, coordinated through an accountable GP lead. These reviews are conducted in a multi-disciplinary team environment directly utilising the expertise of both health and social care professionals at regular meetings. Based on the output of modelling and stratification we will monitor the impact on hospital admission within the next year. Multi-professional discussions inform high risk case management. Joint assessment for adults with mental health needs is already in place and adults with a learning disability are benefiting from the involvement in the IPC programme.

Within this context, our PACS Vanguard has the following key objectives:

Ensuring patients and care professionals have access to a shared care record wherever and whenever needed. This work has two aspects:

a) Action to improve ‘here and now’ access to technology, supporting integrated clinical practice

b) A strategic intra-operability project: introducing a paperless integrated care solution across all providers which builds on the well-established Hampshire Health Record to provide

- Common health record
- Integrated workflow
- Alerts and triggers

The key milestones for 2016/17 are:

Improvements to existing systems and practices

- Single sign on rolled out to all practices and to Ambulance Service by May 2016
- Farnham hub IT in place by May 2016
- Data uploads from Frimley Health to Hampshire Health Record (Q2) and from Virgin Care (by end 2016)
- Upgraded IT infrastructure for remaining Integrated Care Hubs from October 2016
- Single sign on implemented for care homes by end March 2017
- Strategic Intra-operability Project

CONSEQUENTIAL IMPACT ON PROVIDERS

The PACS Vanguard is a system owned programme, with the model of care as well as the impact to individual organisations owned by the whole system. We are striving for a whole population management approach.

The programme governance gives all partners an equal membership, responsibility and voice alongside local communities to design and deliver our whole population management approach. During 2016/17, we will be working with the National New Care Models team to further explore governance models to further support the running of our whole population approach.

The North East Hampshire and Farnham population is served by strong healthcare providers (dominated by NHS Foundation Trusts), including strong primary care, and strong local authorities. Providers have good reputations for the quality of their services. The geographical position of North-East Hampshire and Farnham, straddling two counties, results in services for the population being provided by a large number of organisations. The main providers and commissioners of health and social care services to the population, who are also the partners in this programme, are:

- Frimley Health NHS FT (Acute Hospital provider)
- 24 General Practices in North East Hampshire and Farnham
- Southern Health NHS FT (Community Services provider for North East Hampshire)
- Virgin Care Ltd (Community Services Provider for Farnham population)
- North Hampshire Urgent Care (Out of Hours Primary Care Provider)
- Surrey & Borders Partnership NHS FT (Mental Health/Learning Disabilities Services Provider)
- Salus Medical Services Ltd (GP Federation)
- Hampshire County Council
- Surrey County Council
- North East Hampshire and Farnham Clinical Commissioning Group
- NHS England (Commissioner of primary care and specialist services)

The programme is also working with District and Borough Councils, Nursing Homes, and Domiciliary Care providers to develop the new care models.

ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE – LOCAL SUMMARY

<u>Plans to support people not to be delayed in hospital</u>

As a system, we have spent considerable time examining the root causes of our delays, using data, operational experiences and the experiences of local people using our services.

This work is being developed into a system wide action plan. The key features of this plan, which map across to our Vanguard model of care are:

- An increase in care at home.
- An increase in people being treated at home.
- An increase in the number of people being treated in primary care and community health.
- A reduction in the number of people admitted to care homes.
- Reduction in admissions from Care Homes.
- Reduction in number of people admitted to care homes on perm basis.
- Reducing the rate of admission to hospital
- Eliminating delayed transfers of care.

- Eradicating waits in hospital for assessment or for decisions about ongoing care needs.
- An increase in interim step down provision e.g. discharge to assess.
- Reduce delayed transfers of care across the whole local system.
- Encourage timely decision and joined up discharge planning across the sector.
- Reduce the number of continuing healthcare assessments in the acute setting.

The core components of our Vanguard new models of care that will support these priorities are:

Enhanced primary care and locality based integrated multi-disciplinary teams where GPs and care professionals from community care, mental health and social care:

- Identify those individuals at risk in their locality
- Develop a holistic care plan with each of these individuals, and
- Work as a single team, with the voluntary sector, to deliver joined up health and social care for those individuals, proactively managing the health and social care needs of the population.

Improved local access to specialist expertise and care redesigning the interface between hospital and primary care so that:

- Patients with complex needs have better access to specialist expertise in the community, with hospital consultants providing input to locality Multi-Disciplinary Teams
- Establishing a strengthened rapid community response service to avoid hospital admissions and to enable earlier discharge from hospital.

These priorities will be delivered through the following work programmes by:

GPs working in Frimley Park Hospital, in A&E and on hospital wards:

- A pilot to test the impact of two GP roles in Frimley Park Hospital - Emergency care GP liaison – 8 sessions/week of GP input in Emergency Department and/or ambulatory care and Extended stay
- GP liaison – 6 sessions/week of GP input to help facilitate timely movement of medically fit patients into the community.
- reviewing community bed provision and expanding capacity for community based assessment and reablement, to reduce delays in hospital
- providing community based consultant input to locality teams
- The ‘Enhanced Recovery and Support at Home’ service; established by bringing together teams in Southern Health, Frimley Park Hospital and Hampshire County Council to work as one, providing a co-ordinated rapid response.

Wider enablers to reduce delayed transfers of care.

- Hampshire discharge to assess model. The Discharge to Assess project is designed to support patients who are clinically stable but require a longer period of reablement and rehabilitation up to a six week period. They will not have acute medical needs and will be medically fit for discharge from the acute hospital and no longer require the care of a consultant. The aim of the Discharge to Assess service is to:

  - allow for an assessment of future health and social care needs to take place in a non-acute environment;
  - allow time to maximise the persons potential for independence through provision of reablement services;

- await the provision of residential placement or a domiciliary package for those with high levels of physical dependency (including non-weight bearing) who require basic nursing care; and
- provide a safe place for those who are clinically stable but cannot yet return home.

This service is evaluating well and will be rolled out across our CCG area during 2016/17

- Use of ALAMAC system and kitbag to better operationally manage the system together, ensuring that triggers for performance are identified early and acted upon.

- Localisation of Continuing Healthcare into the new models of care. This will enable improved joined up working with the Frimley Park Hospital discharge team and reduce the length of time taken to complete CHC assessments within the community.

- Frimley Outreach Reablement Team service. This is a discharge support service which supports patients for up to 6 weeks with discharge support from Healthcare Technicians, Occupational Therapists, Physiotherapists and Frimley Park nursing team.

- Rapid Response is an admissions avoidance scheme where individuals are supported for up to 2 weeks in the community with support from Healthcare Technicians and Community Nurses.

- Enhanced Recovery at Home is a service being developed which will bring together The Frimley Outreach Reablement Team and the North East Hampshire Rapid Response Team into one service. The aims of this service will be to support individuals earlier to avoid hospital admissions and for those individuals who are admitted to hospital to work with a team of professionals to reable and rehabilitate to ensure swift discharge from hospital and prevent future re-admissions.

- British Red Cross Support at Home scheme supports patients who are deemed medically fit for discharge from Frimley Park Hospital. The scheme is free to service users and offers flexible, short-term, tailored, low level support to help sustain independent living, support may include:
  - Escort and transport from hospital and settling in
  - Help with shopping, collecting prescriptions, emotional support, befriending
  - Providing information, signposting, referrals and facilitating access into other voluntary and community based services
  - Liaising with family/carers
  - Short term medical equipment loan (e.g. wheelchair/commode)

Across our system, we have invested in dedicated and additional social worker capacity to support discharge planning from acute and community hospital settings and the Integrated care Teams multi-disciplinary joint reviews.

Work is underway to explore opportunities for a multi-disciplinary discharge bureau at Frimley Park Hospital to enable joined up discharge planning and reduced delays. This work will span the 3 key council areas which interface with the Frimley Park Hospital site, Hampshire County Council, Surrey County Council and Bracknell Forest Council.

NORTH WEST SURREY

Overview – other related Strategic Plans in development:

- Annual Operational Plan 2016/17 (currently draft; will be submitted to NHS England)
- Surrey Heartlands approach to the Sustainability and Transformation Plan

DELIVERING 7 DAY SERVICES

North West Surrey CCG's Operational Plan for 2016/17 sets out our approach to delivery of seven day services designed to prevent unnecessary non-elective admissions and support timely discharge of patients from acute settings.

Our social care and community health services work across the system seven days a week, to coordinate services to keep people out of hospital and/or to return them home as soon as possibly following hospital admission.

Key elements of our forward plan for 2016/17, include the following developments:

- Continued implementation of our three Locality Hubs, which bring together primary care, community health, social care, mental health and voluntary service provision to a key group of frail older patients with complex needs and long term conditions.
- Strengthening our primary care delivery system, including the development of a practice federation, designed to deliver primary care services at scale and proactively manage the health of the local population, as part of our 2017 Model of Care.
- Re-commissioning and re-procurement of our Community services, within the GP-led model of community care.
- Development of our Discharge to Assess project, jointly sponsored by the CCG, Adult social care, Virgin Care Surrey Ltd and Ashford and St Peter's Hospitals NHS Foundation Trust.
- Formal launch of the Woking Safe Haven, designed to support people in mental health distress or crisis, preventing avoidable acute admissions. The Safe Haven at Marjory Richard Centre opened with a soft launch in December 2015, open seven days a week (Monday to Friday till 11pm, and Saturdays and Sundays 12 noon to 11pm). The Safe Haven forms part of our Crisis Concordat actions and is a collaboration between the CCG, voluntary sector, secondary mental health services, Woking Borough Council and other partners.
- Increased involvement of the voluntary sector in supporting our transformation, prevention and independence agenda – initially providing a care navigator role in the Locality Hubs, but with plans to develop into a wider model of social/wellbeing prescribing.
- Care Homes advice line commissioned from Care UK operates out of hours (evenings and weekends) to give support to care homes in managing patients and avoiding unnecessary A&E attendances, overseen by our Care Homes MDT.
- Development of a robust, substantive model of acute mental health liaison services at Ashford and St. Peter's Hospitals Trust (ASPH), based on NHS England's Core 24 standards, in partnership with Surrey and Borders Partnership FT.

Investment through the BCF continues to support our wider programme of work through community health services, social care and the voluntary sector. In particular, BCF investment is supporting:

- Maintenance of social care hospital staffing.
- Maintenance of social care reablement staffing supporting discharge from hospital.
- Capacity in community health services, including spot-purchased community beds.

We will be developing a more co-ordinated “Home from Hospital” service, commissioned from the voluntary sector, bringing together services currently provided from two separate services, supporting non-complex discharges with short-term practical help for people who might otherwise be vulnerable to readmission.

JOINT APPROACH TO ASSESSMENT AND CARE PLANNING

North West Surrey’s approach to risk stratification and multi-disciplinary working around complex case management remains as set out in previous plans for our Integrated Care programme and the Locality Hubs.

In 2016/17, as we build towards our 2017 Model of Care, our aim is to embed our Integrated Care model across our system and across our practices to demonstrate a significant impact on avoidable admissions. North West Surrey continues to encourage the development of the primary care practice federation model, with practices working together at scale across a larger footprint.

Further investment in primary care will enable a more proactive approach to managing population health and will deliver better outcomes, particularly around Extended Primary Care, to deliver an enhanced model of provision of primary care services across North West Surrey. The scope of this initiative potentially includes the delivery of 7 day primary care access, Assessment & Treatment facilities, Minor injuries services, Near patient testing, Ambulatory care pathways and direct access to Community beds. Our enablers for this work include Locally Commissioned Services, including PMS Review reinvestment, and our Local Incentive Scheme (Practice Delivery Scheme),

Integration of services within and around the hubs includes social care, community health, mental health and voluntary sector services. Our objective is to localise care, and improve responsiveness and management of patients with complex needs and long term conditions. As part of our plans we will proactively monitor access and uptake, to ensure we are meeting urgent and unscheduled care needs of our patient cohort and their carers.

We are in the process of co-designing our dementia strategy, as part of our integrated, community-based model, including plans for improving post-diagnostic support and widening interest in dementia-friendly communities. This will be key to ensuring that our population of patients with dementia and their carers are supported effectively in the community and do not need to seek hospital services, inappropriately for their care, where a community-based option is available.

CONSEQUENTIAL IMPACT ON PROVIDERS

Engagement with providers across North West Surrey health and social care system is structured around existing arrangements: the monthly NWS Transformation Board, led by the CCG and bringing together acute, community, social care, mental health and ambulance services and also through the leadership of the NWS Cabinet. The Cabinet (CCG, ASC, ASPH and Virgin Care Community services) has jointly sponsored our Discharge to Assess BCF project. The impact of our schemes is discussed and agreed with our providers, with a clear focus on reducing non-elective admissions and delayed transfers of care, supported by the work of our System Resilience Group (SRG).

At an operational level, the new service model is co-designed with acute clinicians, primary care, therapies, social care and community services. The impact on the workforce of each development is considered and negotiated as part of this process.

Through the annual contract negotiation process, the CCG is agreeing the acute activity with Ashford and St. Peter's Hospitals FT with the objective of a single, agreed activity plan, aligning the efficiency plans of both organisations (QIPP plans and Trust Cost Improvement Plans). The block contract with Virgin Care Surrey for community health services has been supplemented with additional investment as we move towards the new model of care.

This process will be extended in the coming months as we refine and agree our Surrey Heartlands Sustainability and Transformation Plan for submission in June 2016, building on the work already undertaken to refresh our 5-year strategic commissioning plan for North West Surrey. The CCG engaged widely with its commissioning partners, local providers, stakeholders and wider population in reviewing and refining its plans.

Our wider engagement strategy, led by our Patient and Public Engagement Forum, includes engagement via our practice Patient Participation Groups.

Our plans in 2016/17 include improved integration of mental and physical health services are being developed as part of the wider strategy to develop integrated services that address whole-person health and wellbeing. This will include increased access and uptake of primary care mental health services (IAPT) integrated into our Locality Hubs and acute hospital, reducing reliance on secondary care mental health services through appropriate earlier intervention.

ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE – LOCAL SUMMARY

Delayed Transfers of Care are monitored on a daily basis, through our Alamac Kitbag – an on-line dashboard available to all partners in the care system. Supported by leadership through our SRG, the Kitbag enables the system to pinpoint system pressures and act quickly in response. Our local system responses include:

- Seven-day social care assessment services in the acute hospital, maintained with BCF funding
- Community health services seven day working within both acute and community settings, via the Rapid Response team
- Strong systems, processes and working relationships between the partners in North West Surrey, based around Ashford and St. Peter's
- Rapid response and reablement services managing the acute to community interface
- Telecare
- Integrated Multi-Disciplinary Discharge Team working at ASPH – co-located and integrated community, social care and acute discharge team
- Spot-purchased community and care beds, to flex capacity up and down as needed
- Discharge to Assess scheme (under development)
- Voluntary sector Home from Hospital services through British Red Cross and Age UK (Further integration under development)

OUT OF HOSPITAL SERVICES

NHS North West Surrey Clinical Commissioning Group (NWS CCG) has developed a high level blueprint that represents the vision for the broad range of health and care services across the system which will enable us to achieve our strategic objectives. We have called this blueprint our Model of Care and, whilst this model will continue to adapt and evolve over time, we have chosen 2017 as a key transition point as

this aligns with the commencement date of services to be provided under the **Community Health Services procurement** exercise that launched in February 2016 and provides an opportunity to bring about fundamental system redesign.

The Model of Care brings together a number of themes including ambitions, objectives, capabilities, care settings, teams, facilities and enablers with the objectives of:

- providing a framework for system-wide changes and priorities; and
- setting the strategic context for detailed service design work, including service specifications.

NWS CCG aspires to deliver a transformed Out of Hospital Care environment that sees community services, mental health services, social care services and the voluntary sector working much more collaboratively around a central care plan with core clinical direction and leadership coming from a developed and organised primary care sector.

Through the Community Health Services procurement, NWS CCG seeks to procure a range of Community Health services primarily for Adults aged 18 plus that delivers a proactive approach to care that identifies and supports vulnerable people in the community, prevents serious illness and provides timely coordinated care in a way that integrates the Out of Hospital care and support system.

The award of the contract will represent a critical milestone towards implementing our vision, enabling the delivery of a step change towards delivering the system wide model of care, building upon the good work that has already been achieved. Our new model of care, evolving from 2017 onwards will require the Provider to focus on the creation of an organised, coordinated and effective Out of Hospital provider environment that is seen as the main conduit for meeting a person's health and care needs.

In parallel, we have partnered with the Surrey CCGs, Surrey County Council and NHS England to jointly procure **Children's Community Health Services**. This procurement is being led by NHS Guildford and Waverley CCG.

Procurement of an integrated multi-disciplinary musculoskeletal service

Further to the successful piloting of an Integrated Musculoskeletal Service for adults, NWS CCG seeks to improve MSK Services for the local population due to concerns over waiting times, uncoordinated services that patients and GPs find difficult to navigate and increasing spend on MSK Services. The Commissioning for Value Right Care data indicated opportunities for savings on MSK Elective care if the CCG performed at the average of 10 similar comparator CCGs.

NWS CCG is seeking a Prime Provider who will be required to deliver an integrated system pathway for MSK Services where the patient experiences a seamless and prompt service across their entire journey. The service model emphasises prevention and self-care, with the patient as an active participant.

The service is due to commence on 1st October 2016, replacing the current interim MSK service.

NHS 111 & GP Out-of-Hours Procurement

The current contract for the Kent, Surrey and Sussex wide NHS 111 service expires on the 31st March 2018. However, NWS CCG anticipates an early exit in October 2017 to align with the expiration of the current GP Out of Hours contract serving NHS Guildford and Waverley CCG, NHS North West Surrey CCG and NHS Surrey Downs CCG. This will allow commissioners to conduct a competitive exercise incorporating the National Commissioning Standards for Integrated Urgent Care which were published in October 2015.

The National Urgent and Emergency Care Review highlighted areas that have entirely separate working arrangements between NHS 111, OOH and other urgent care services and recognised that such disjointed services no longer fully meet the needs of patients or health professionals.

The need to redesign urgent and emergency care services in England and the new models of care which seek to address this are set out in the Five Year Forward View (5YFV).

The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions.

Patient Transport Service

NWS CCG is leading a competitive procurement to appoint a prime provider for the provision of a Non-Emergency Patient Transport Services (NEPTS) on behalf of the following CCGs:

- NHS East Surrey CCG
- NHS Guildford & Waverley CCG
- NHS Hounslow CCG
- NHS North East Hampshire & Farnham CCG
- NHS North West Surrey CCG
- NHS Surrey Heath CCG

The procurement commenced in January 2016 and the service will commence in April 2017.

The contract to be awarded encompasses the provision of a high quality efficient NEPTS which is capable of integrating community transport providers thereby being responsive to the patient needs. The model promotes the integration of the Central Booking Service with patient transport and community transport. The Provider will be responsible for the NEPTS care and delivery along with the financial and budgetary management, budgetary analysis and overall contract management of the system pathway. The Provider will be required to deliver an integrated transport and booking service that envisages the patient experiencing a seamless service across their entire journey.

Voluntary Sector Grants

NWS CCG grant funds 14 voluntary organisations to help them support our aims for promoting good health, preventing disease, extend independent living and care for the community outside of a hospital environment. This year (16/17), our grant agreements will be extended for a 6 month period in order to facilitate a system wide review of this funding. The grants will be assessed for quality and positive impact on the community. We will also measure whether they are meeting the aims for which we originally began the funding and whether those aims are still required in the same way.

In addition to these reviews, we are working closely with SCC to develop further joint funding agreements, where both parties are grant-funding the same organisations. Going forward, our aim is to have one agreement from the public sector with each voluntary organisation rather than multiple agreements. This will allow for efficiencies to be made and also give higher levels of security, due to the possibility of longer term funding arrangements and reduce complexity with regards to invoicing and management for these organisations.

We have established a voluntary sector engagement forum where groups are invited to engage, discuss how they can support in addressing our priorities and considering possible changes and developments; It has been a very positive step. We see the sector as invaluable partners in service delivery and expect

that they will be key players in the future of healthcare for NWS. In specifying the model for the adult community services procurement, we have included a requirement that the provider is to engage with the voluntary sector as part of service delivery. The voluntary sector is also being engaged with around the procurement of early discharge services and being made aware of other opportunities.

Action Plan – LJCG Work Programme for 2016/17

Topic	Actions	Timescale
Governance	Agree LJCG work programme for 2016/17 Ensure final agreement and signature of BCF Section 75 agreement Review and update LJCG Terms of Reference and reporting structure Agree standard agenda for LJCG review, including monthly finances report; quarterly metrics report. Timetable programme of regular reports from the three enabler projects for oversight and assurance: • Workforce integration • Equipment and Adaptations • Information and record sharing. Ensure that NWS have completed all actions against the recommendations of the recent audit of Governance Review effectiveness of LJCG and achievement of 2016/17 objectives Lead planning process for 2017/18	April 2016 May 2016 May 2016 May 2016 June 2016 January 2017 Jan-Mar 2017
Integration	Monitor progress of Integrated Frailty Programme and implementation of Locality Hub pilots during 2016/17, through receiving regular reporting from the programme. Identify any potential additional opportunities for further development and alignment Ensure LJCG is kept informed about the Community Services re-procurement at key stages to ensure alignment and delivery of joint objectives Discharge to assess - review at key stages leading to implementation by October 2016	April 2016 - on going October 2016
Voluntary sector grants:	Complete review and mapping across CCG, SCC, Boroughs Initiate Procurement of new home from hospital service for delivery from October 2016 Explore further opportunities for lead commissioning, to avoid duplication and improve efficiency as part of ongoing review cycle Develop and agree joint proposals for 2017/18 – Establish voluntary sector funding agreements for 2017/18	Oct 2016 Oct 2016 April 2016 onwards End September 2016 Jan - March 2017

Prevention agenda	Receive and agree an update of the Prevention Plan; Plan is to incorporate public health, targeted work with communities, secondary health prevention, promoting independence, building resilient communities) for agreement by partners Integration of services and service planning across CCG, SCC public health, ASC and where appropriate Children's services and Boroughs. Monitor progress against objectives of the NWS Health and Wellbeing Programme.	July 2016 Ongoing
Social/ wellbeing prescribing	Further consultation to scope model for NWS Develop detailed Borough level plans Implement local plans Review and realign as needed with evolving Community services mobilisation Evaluation and agreement of next steps	April - May 2016 May - June 2016 July onwards Oct 2016 - March 2017 Jan - March 2017
Equipment and adaptations	Local scoping meeting with Boroughs, ASC and CCG Discussion at LJCG (with Boroughs) and strategic agreement on next steps Development of detailed plans Implementation of agreed action plans	April 2016 May 2016 Jun – Aug 2016 Sept - March 2017

SURREY DOWNS

This document provides a brief summary of the key actions of the Surrey Better Care Fund Plan. The plan locally has evolved through the developing partnership and relationships in Surrey Downs, and the latest iteration reflects the significant amount of collaboration and co-design that has taken place over the last two years across the local health and social care economy.

Context

The Better Care Fund (BCF; previously called the Integration Transformation Fund or 'Whole Systems' in Surrey) was announced by the government in June 2013. The BCF utilised existing NHS funds, and was designed to integrate aspects of health and social care under a local pooled budget in order to "incentivise the NHS and local government to work more closely together". Each CCG and its matching Local Authority were required by NHS England to submit a jointly agreed plan during 2014. The delivery of plans is overseen by the Health and Wellbeing Boards.

The Surrey Downs plan is part of the overarching Surrey wide plan and was approved by NHSE in February 2015. The plan had 5 designated schemes operating in Surrey Downs CCG:

- An enhanced, developed primary care service operating in networks of practices
- Ensure improved patient experience and outcomes within the continuing care assessment process through
- An Urgent Care and Discharge System that works to enable people to return home earlier in their recovery pathway
- Facilitate rapid discharge for those people with high risk of hospitalisation through a more responsive and effective Intermediate Care/Reablement teams.
- Integrated services to reduce admission (Enhanced Case Management)

Extensive information has been produced regarding the demographic pressure of our ageing community. Whilst it is a positive outcome of previous health improvements that life expectancy has significantly increased, there is now an urgent requirement for the NHS to more effectively plan for the ageing population. This is a particular concern for the Surrey Downs CCG population and is reflected locally in the SDCCG "Out of Hospital" and the Primary Care Strategies which aim to move care out of acute settings and increase and improve intermediary care closer to patients' homes.

The CCG also recognises that as part of its overall strategy, there is a need to keep the population healthy via encouraging health lifestyle choices. By having an active Prevention programme, the CCG aims to reduce obesity rates, smoking rates and reduce harm caused by substance misuse, including alcohol.

For 2016/17, the CCG and the Local County Council will be operating in difficult and constrained financial circumstances and spending will be reviewed in line with prioritisation principles.

Principles and Governance:

The CCG and Local County Council are members of the Local Joint Commissioning Group (LJCG). This group meets on a monthly basis and is responsible for the oversight of the Better Care Fund Programmes for Surrey Downs CCG and reports up to the BCF Programme Board who report to the Health and Well Being Board. As part of the LJCG's work, they will be reviewing the allocation of spend based on agreed principles. The following are the current draft principles:

- Take a local commissioning view of all grants and contracts
- Focus on services that delivery statutory requirements and have the largest impact on meeting prevention priorities and delivering the Five Year Forward View
- All local services should align with Prevention priorities or the Five Year Forward View
- Co-design and work with the community to understand impacts on residents, clients and patients
- Work on a place based principle

ANNEX TWO – LOCAL ACTION PLANS / NARRATIVES

Surrey Downs CCG, working with the LJCG, has taken a locality-level approach to delivering Health and Social Care Integration. The Surrey Downs area has three distinct localities flowing into three acute Trusts: Epsom, East Elmbridge and Dorking. Each locality is developing its own integration delivery approach reflecting local challenges, key elements of which are:

- Community Medical Teams (CMTs), run by local GP networks, leading community-based crisis response care, managing local community hospital beds and acting as the fulcrum of the model of care
- Community Hubs, working with CMTs to manage a caseload of high risk patients identified through acute exacerbations and risk stratification
- Engagement with Adult Social Care to provide responsive reablement services and to fully mobilise local District and Borough and third sector support mechanisms, with a personalised plan around each individual

2016/17 Action Plan

The following table is a high level action plan of 2016/17 actions which will be overseen by LJCG and implement by local partners and stakeholders

No.	Title	Date
1	Refresh Prevention Plan	April 2016
2	Develop common STP Prevention Plan	June 2016
3	Mobilisation of Epsom Locality integrated teams	Q1 2016
4	Go live of Epsom Locality integrated Teams	Q2 2016
5	East Elmbridge and Dorking Integration Business case development	Q1 2016
6	East Elmbridge and Dorking Integration Mobilisation	Q2 2016
7	East Elmbridge and Dorking Integration Mobilisation	Q3 2016
8	Review of BCF, grants and contracts spend	April 2016
9	Implementation plan development pending outcome of Review	May 2016

The LJCG is supportive of the Integration Programmes and implementing the vision in the Five Year Forward View. The integration programmes at a locality level are focused on ensuring that a holistic approach is taken when managing a patient. This includes having 8 am to 8 pm and weekend working in-reach programmes to facilitate discharge.

The key detail of the Surrey Downs local action plan and narrative in relation to meeting the BCF national conditions can be found in the Epsom Health and Care Integrated Business Case 2016/17 and 2017/18 document published on the CCG website.

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SURREY HEATH

DELIVERING 7 DAY SERVICES

SHCCG's Operating Plan for 2016/17 sets out the overall approach to delivery of seven day services designed to prevent unnecessary non-elective admissions and support timely discharge of patients from acute settings.

Social care and community health services already work across the system seven days a week, coordinating services to keep people out of hospital and to return them home as quickly as possibly following an acute admission.

Key elements of the CCG's plan for 2016/17 include:

- Continuation of extended routine general practice across our community (Monday to Friday 8am to 8pm working) aligned with:
- Monday to Friday 8am to 8pm working of community nursing (physical and mental health) services and the voluntary sector within our integrated care hubs and single point of access
- Re–procurement of NHS 111 and GP OOH services to provide a functionally integrated urgent and emergency care service across 24/7.
- Review across health and social of access to home and bed based care to improve access on discharge from hospital across 7 days and reduce delayed transfer of care
- Review rehabilitation and reablement services within Surrey Heath to identify potential improvements that would support admission avoidance and reduce discharge delayed over the 7 day period
- Implementation of acute centric 7 day service requirements as per 2013/14 7 day Clinical Standards)
- Establishment of ongoing funding stream for local Safe haven to support people in mental health distress and avert crisis, preventing avoidable acute admissions.
- Review of the existing clinical model supporting people in nursing and care homes with the aim of developing a single, coordinated support service for nursing and residential care homes with enhanced medical and specialist nursing support, focus on maintaining functional ability, to reduce conveyances and admissions from care settings.
- Review of the current falls and fractures pathway to improve follow-up in the community and reduce the number of repeat falls and fractures.
- Continuing to commission 24 hour psychiatric liaison services at Frimley Park Hospital in conjunction with NEHF CCG and Bracknell and Ascot CCG

More broadly, investment through the BCF continues to support timely discharge through building or maintaining capacity in community health services, social care and the voluntary sector. In particular, BCF investment is supporting:

- Maintenance of social care hospital staffing.
- Maintenance of social care reablement staffing supporting discharge from hospital.
- Capacity in community health services, including spot-purchased community beds.
- Voluntary sector "Home from Hospital" service, designed to support non-complex discharges with short-term practical support for people who might otherwise be vulnerable to readmission.

Contribution of the Borough Council to this agenda via PPP funding

JOINT APPROACH TO ASSESSMENT AND CARE PLANNING

During 2016/17 Social Care Locality Staff will be fully integrated into the Integrated Care teams and Single Point of Access within Surrey Heath. This team will:

- Share a risk stratification* approach to identify those that will most benefit from integration. Work to map existing systems and processes has already been commenced.
- Already each individual on the Integrated Care Team caseload has a named care co-ordinator. This individual is also the point of contact for carers. As mental health is fully integrated within this team this applies to people with dementia as well as those with complex long term conditions.
- There is already a network of dementia navigators across Surrey and this role will be reviewed locally as part of a full assessment of dementia pathways during 2016/17. A local Dementia Strategy group with membership from across Surrey Heath is already established and chaired by the Director of Adult Social Care. A local dementia strategy will be completed in early 2016/17. The CCG has made significant investment in the older person's community locality team (nurses and additional consultants). The benefits of this will be fully realised in 2016/17.

*Risk stratification – the EMIS IQ risk stratification tool is used in primary care having been implemented in 2014 to support the National unplanned hospital admissions enhanced service (DES) which required the top 2% of the population over 18% and at risk of admission to have a coordinated care plan.

CONSEQUENTIAL IMPACT ON PROVIDERS

A local system leadership group has been established - the Surrey Heath Care Alliance. There is close alignment between the aims of the BCF and the agreed strategic outcomes form this group. The impact of our local BCF plan on providers will be discussed through this forum. Membership includes representation from community physical and mental health services, our main mental health and acute hospital, social care, public health, SHCCG, general practice (in and out of hours) and the voluntary sector.

Key components of the 16/17 BCF plan, especially greater integration, have also been discussed with our local population through regular joint engagement events across health and social care.

ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE – LOCAL SUMMARY

The DTOC performance for Surrey residents admitted and discharged from Frimley Hospital is good when benchmarked nationally and against other counties supporting discharge from Frimley (Hampshire and Berkshire) our challenge is to maintain this performance within the context of a rapidly ageing population and rising demand/complexity of admission. This strong performance which is predicated on:

- Social care seven day services within the acute setting, maintained with BCF funding
- Community health services seven day working within both acute and community settings, maintained with BCF funding
- Strong systems, processes and working relationships between the partners based around the Frimley health economy
- Schemes funded or maintained through the BCF and activities including the Surrey Heath Home Care and Care Home provider forums
- DTOC performance is monitored across the Frimley System through the System Resilience Board which includes membership from both SH Adult Social Care and SHCCG.