Surrey Better Care Fund Plan 2017/18 & 2018/19

September 2017

SURREY BCF 2017-19 NARRATIVE PLAN

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INTRODUCTION

The Surrey Better Care Fund plan 2017/18 + 2018/19 builds on the progress made over the previous two years of the Better Care Fund and, in consultation with a range of partners across Surrey, has been jointly produced and signed off by:

- NHS East Surrey Clinical Commissioning Group
- NHS Guildford & Waverley Clinical Commissioning Group
- NHS North East Hampshire & Farnham Clinical Commissioning Group
- NHS North West Surrey Clinical Commissioning Group
- NHS Surrey Downs Clinical Commissioning Group
- NHS Surrey Heath Clinical Commissioning Group
- NHS Windsor, Ascot & Maidenhead Clinical Commissioning Group
- Surrey County Council

Surrey is one of, if not the most, complex health and care systems in the country. Surrey has 1 county council, 7 CCGs, 11 district and borough councils, 5 acute hospital trusts, 1 mental health Trust, 3 community care providers and 130 GP surgeries – not to mention the wide range of other providers, voluntary and community organisations that deliver essential health and care services to Surrey residents. Adding to the complexity, though also supporting the development of a richly layered systems leadership, Surrey also has three STP footprints within its borders:

- Frimley Health and Care – covering the geographic areas of Surrey Heath and North East Hampshire and Farnham CCGs (also covering areas outside of the county)
- Sussex and East Surrey – covering the geographic area of East Surrey CCG (also covering areas outside of the county)
- Surrey Heartlands – covering the geographical areas of Guildford and Waverley, North West Surrey and Surrey Downs Clinical Commissioning Groups (CCGs)

Partnership within Surrey Heartlands STP have matured to the point to sign a Devolution Agreement with NHS England and NHS Improvement with the intention to:

- *Accelerate the integration of health and social care through much closer working between partners*
- *Increase public engagement and the involvement of the people of Surrey Heartlands around the transformation of health and social care*
- *Increase local decision-making and flexibilities to achieve the best possible outcomes for the local population*

The next five years will be exceptionally challenging – an ageing population, increasing demands on services and our collective financial pressures necessitate a continued radical shift in the way services are delivered. But we are committed to ever closer integration in our health and care system and our BCF and STP plans to date demonstrate how we will work together to deliver better outcomes for the residents of Surrey whilst meeting those challenges.

Better Care Fund is a national programme announced by the Government in the June 2013 spending round. The aim of the programme is to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. 2017/18 + 2018/19 will be the third and fourth years of the Better Care Fund programme.

Surrey Better Care Fund Plan should be read in conjunction with:

- Surrey Better Care Fund Plan 2015/16 + 2016/17
- Clinical Commissioning Group Operating plans 2017/19
- Surrey County Council Corporate Strategy 2017-2022
- Surrey County Council Medium Term Financial Plan 2017-2020
- North East Hampshire & Farnham Vanguard documentation
- CCG Operational Resilience and Capacity Plans
- Epsom Health and Care Integrated Business Case 2016/17 and 2017/18
- Surrey BCF Graduation Expression of Interest

This plan has been developed alongside the Sustainability and Transformation Plans (STP) covering Surrey,and their respecitve digital rodmaps. Surrey Heartlands + digital roadmap, Frimley Health and Care + digital roadmap, Sussex and East Surrey + digital rodmap.

NATIONAL CONDITION 1 – A JOINTLY AGREED PLAN

ALL PARTIES SIGNED UP TO THE PLAN

This plan has been jointly produced and signed off by Surrey County Council and the Surrey CCGs. The plan was signed off by the Surrey Health and Wellbeing Board on 7 September 2017. In the lead to this, local plans and expenditure were agreed at Local Joint Commissioning Groups, and the countywide Health and Social Care Integration Board

The BCF Planning Return sets out clearly the contributions to the Surrey BCF – this is in line with the mandatory minimum contributions as per the guidance on national conditions.

In developing the local plans that this BCF plan is built upon, local providers have been engaged by each of the Local Joint Commissioning Groups. Engagement is not seen in Surrey as a one-off event – it is a crucial ongoing activity that informs planning and decision making throughout the year. And within STP governance, planning and project delivery, local providers are equal partners and a key part of the delivery of integration and place-based solutions.

The important role district and borough councils play in the provision of local preventative services, engagement within local communities and as the local housing authority, is fully recognised in Surrey – engagement takes places at a LJCG level and there are three district and borough representatives on the Surrey Health and Wellbeing Board. The Disabled Facilities Grant for 2016/17 will be pooled and cascaded to the 11 district and borough councils in line with the national guidance with discussions in each locality to agree the use of the funds.

LEARNING FROM THE PAST TWO YEARS

The use of the Better Care Fund, Improved Better Care Fund and Disabled Facilities Grant will continue to build on the progress made in 2015/16 and 2016/17, and will continue to be planned and delivered by a wide-ranging partnership, across Surrey's health and care system.

The Better Care Fund over the past two years has provided the health and care system in Surrey with significant opportunities and challenges – as a system, we have learnt a huge amount from our experience in developing plans, negotiating and agreeing governance arrangements, and through the implementation of our plans. Our governance and accountability arrangements in the Surrey system are now well matured, and have served well in the building of our STPs and will drive the delivery of integration across Surrey in the coming years.

Our local joint commissioning arrangements have enabled us to share and use our learning to inform local plans and actions throughout the previous two years, giving local flexibility to adapt to changes in need, performance or circumstances. At a Surrey-

wide level we have actively sought feedback to shape our approach – for example, BCF progress forms the basis for Health & Wellbeing Strategy priority of "Improving older adults' health and wellbeing" presented every six months to the Health & Wellbeing Board. At local and Surrey-wide levels, Healthwatch Surrey has continued to provide challenge and support to ensure that patient and service user experience is included as a key factor in determining progress and shaping plans. Surrey County Council Internal Audit team have also conducted an audit of the BCF process each of the two years it has existed, with recommendations being implemented. Surrey has also applied to Graduate from the BCF process, and this has provided the system an opportunity to review and reflect on its challenges and progress towards integration by 2020.

Surrey has also supported sector led improvement, for instance by sharing best practice at BCF network events, being a test area for the LGA integration self-assessment tool at a Health and Wellbeing Board session in 2016, and have volunteered to support QORU's system-level evaluation of the BCF.

In reviewing BCF over the previous two years, we have identified a range of examples where we have made significant steps forward including:

- The establishment of integrated care teams in various forms across the county – these are already delivering better, joined up care and we have been able to learn from pilots to shape and adapt our plans to maximise the impact of changes we are making. For example the Epsom Health & Care Alliance arrangement in Surrey Downs CCG have built an integrated service to support older people and are already delivering improvements in accident and emergency waiting times, length of stay for unplanned hospital admissions and fewer delays in discharge from hospital.
- Relationships between partners and joined up working across Surrey have grown stronger through 2015/16 and 2016/17, supported by the maturing local governance arrangements, the alignment of Adult Social Care with each of the CCGs and a shared commitment to accelerate and scale integration plans. These relationships provided the sound base upon which our STPs have been built. By way of example, the Chair of the Transformation Board in Surrey Heartlands is SCC's Chief Executive.
- The investment of significant time and effort to accelerate our plans around data sharing and digital transformation – this investment is paying off and the work that is developing around digital roadmaps will play a key enabling role in the delivery of our integration plans. For instance, the Sustainability and Transformation Plans (STPs) and their respective Digital Roadmaps are hoping to implement integrated digital care records over the next two years.

We've also identified areas where we'll need to maintain or place added focus in 2017/18 + 2018/19 – these reflect the areas that we know will present challenges. These include:

- recognition that the pace of change and integration across Surrey needs to increase to meet rising demands, financial challenges and our ambitions for improving people's health outcomes;
- the need to keep developing a more coherent and joined up approach to 'market management' as an important area of focus – this will help to ensure we have the right capacity to meet local needs and support the delivery of our sustainability goals;
- the acceleration of our integration plans places greater importance on the engagement and involvement of patients and service users, and staff in shaping the changes that are being made; and.
- focus on local delivery of HIC models in coordination with respective A&E Delivery Boards, to deliver improvements in helping individuals home from hospital
- continue to coordinate Surrey-based integration plans and vision, across our complex system, and taking advantage of the opportunities in collaboration and shared system learning.

Overall, we have made good progress in a number of areas, both in terms of aligning and integrating services and in building stronger relationships between partners, but there are still significant opportunities to bring services closer together and maximise the benefits for people in Surrey.

SURREY'S CASE FOR CHANGE AND VISION FOR HEALTH AND CARE INTEGRATION BY 2020

Surrey's Joint Strategic Needs Assessment (JSNA) and local health profiles tell us that Surrey has an ageing and growing population. In 2017 the population of Surrey was an estimated 1.19 million people, projected to rise to 1.27 million people by 2025 with the largest rise anticipated in people aged over 65 years.

An increased and ageing population inevitably results in an increase in the number of people living with complex needs such as long term conditions, dementia, falls, depression and loneliness. For example the projected rise in the number of older people living with dementia in Surrey is 28% from 2017 to 2025.

These increasing needs in the population put additional demand on health and social care services in Surrey. There are increases in emergency admissions and emergency readmissions; and in spite of recent improvements in permanent admissions to residential and nursing care homes, there is a shortage of extra care housing available.

Patients and service users have expressed wanting their needs and circumstances to be considered as a whole and highlighted the importance of moving smoothly from hospital to onward community support (in recent Healthwatch England research). This can only be done if health and social care services are integrated, which has proven to improve patients experience of care by reducing duplication and improving access (based upon a recent evaluation of the Inner NW London Integrated Care Pilot).

The Surrey health and social care system also faces significant financial challenges. Despite some funding sources like a council tax precept for Adult Social Care, increased demands and requirements around the use of funds mean that the County Council and each CCG will need to deliver significant efficiency savings (CCGs through through their Quality, Innovation, Productivity and Prevention plans) to achieve balanced budgets. Full financial plans are set out in the Surrey County Council Medium Term Financial Plan, and in CCG and provider operational plans.

Surrey's Health and Wellbeing Strategy sets out a vision for meeting these challenges, which is captured in plans throughout the system, as: ***Through mutual trust, strong leadership and shared values we will improve the health and wellbeing of Surrey people.***

To achieve our vision we have agreed three strategic aims for the BCF:

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*

The Surrey Better Care Fund plan 2017/18-2018/19 maintains the same focus on older adults as previous plans, and is rooted in the Surrey Health and Wellbeing Strategy, which has identified 5 outcomes that our work is intended to achieve:

- older adults will stay healthier and independent for longer
- older adults will have a good experience of care and support
- more older adults with dementia will have access to care and support
- older adults will experience hospital admissions only when needed and will be supported to return home as soon as possible

- older carers will be supported to live a fulfilling life outside caring

Our shared vision, values, strategic aims and the outcomes we seek to achieve align with the national requirements and conditions for the Better Care Fund. Each of our localities use this overarching framework to guide local approaches and action plans – tailoring local solutions to meet local needs and system characteristics.

Surrey's approach to the BCF was developed in the context of the three STPs, and delivery of the vision and actions of the BCF are important steps for the successful delivery of the longer term transformation being developed as part of STPs and crucially in closing the 3 gaps identified in the Five Year Forward View:

- the health and wellbeing gap
- the care and quality gap
- the finance and efficiency gap

In respect of different sovereignties within the Surrey footprints, the health and care system has managed to create complementary visions with significant overlap, and built from shared principles.

This overlap in vision is also evidenced in the objectives of the Surrey Heartlands Devolution Agreement:

- Improve health and social care outcomes;
- Drive integration of services and functions that improve quality and reduce health inequalities;
- Demonstrate public value;
- Increase public engagement in decision-making;
- Standardise best practice in health and social care through commissioning and provision, in order to secure improved outcomes, efficiencies and effectiveness;
- Achieve sustainable financial balance.

GOVERNANCE AND ACCOUNTABILITY

As detailed above, governance and accountability arrangements in the Surrey system are now well matured, and have served well in the building of our STPs and will drive the delivery of integration across Surrey in the coming years. The governance and accountability arrangements of Surrey's approach to the BCF was independently audited in 2017, with the report shared across the system, and recommendations being fed to the Health and Social Care Integration Board for implementation.

Surrey's approach is based upon a principal of subsidiarity – taking decisions at a local level whenever appropriate, through the Local Joint Commissioning Groups (LJCG) established in each of the CCG

areas with membership made up of the relevant CCG, the County Council (which restructured in 2015 to better align adult social care with CCG geographies) and other local stakeholders.

It is at this local level where the development, management and oversight of delivery of local plans takes place, including detailed monitoring of pooled budgets and tracking delivery against BCF metrics. In support of this, monthly Finance reports are prepared, shared and presented at all Local Joint Commissioning group meetings. And once/quarter, the countywide BCF metrics group meets to review and compare performance against key BCF metrics, share learning, and pass this on to LJCGs. These metrics are currently being expanded on as efforts are being made to develop local measures.

In addition to this, this local level is the principal level for engagement with key partners – with providers, district and borough councils, the voluntary and community sector and with patients, service users and the public. These local partnerships form a basis for integration up into a Surrey and STP level.

At a Surrey-wide level, the partnership of the Health and Wellbeing Board is well established and brings together system leaders – local political, clinical, commissioner and community leaders such as the representatives from the District and Borough Councils, the Police and Crime Commissioner and Healthwatch Surrey. It provides oversight and direction to our ever closer integration, with challenge and support from the Council's Wellbeing and Health Scrutiny Board.

And working on behalf of the H&WB, the Surrey Health and Social Care Integration Board (previously the Better Care Board, which changed its name from an ambition to integrate beyond the BCF) provides strategic oversight and leadership at a county level. Specific joint working groups have been established as integration enablers, including workforce, data sharing/digital transformation, equipment and adaptations, integrated commissioning and also a metrics group.

Surrey's three STPs have their own respective boards that determine their direction, but these are supported locally by LJCGs and are also linked to the Surrey-wide H&WB and H&SCIB in membership overlap, and also through regular updates. STPs also have significant representation (and in some cases leadership) in their workstreams from Local Authority officers, but also the Chair of the Transformation Board in Surrey Heartlands is SCC's Chief Executive.

ADDRESSING HEALTH INEQUALITIES AND EQUALITIES

There is a large body of evidence in support of integrating health and social care services for improved and more equitable outcomes for individuals. Alongside the nationally provided evidence and

policy, Surrey has developed local evidence which forms the basis for all strategic decision making. These sources include:

- The Joint Strategic Needs Assessment (JSNA)
- Local population, health and wellbeing profiles
- Local dashboards and priority snapshots
- CCG commissioning profiles
- Surrey PAD

This shared evidence base has been built in partnership, and presents data at various geographies to help all Surrey partners understand their local population health needs and focus services around people, rather than around the structures and organisations that deliver the care. This data includes ward and LSOA level data of health outcomes, indices of deprivation, workforce diversity data and other data and analysis for prevention plans, and to support approaches to tackle health inequalities and inequalities for people with protected charactersitics

Local CCG-level plans evidence the approach to tackling health inequalities and supporting protected equalities groups. As described above, the principles which inform planning flows from the Health and Wellbeing Strategy. All plans which need agreement from the Health and Wellbeing Board need to address health inequalities, as this is a key principle of our system leadership. And outcomes within the strategy, including the priority of "Improving older adults' health and wellbeing", which is the core focus of Surrey's BCF plan, is built from identified health inequalities, and supporting protected equalities groups. For example, the outcome to support older carers to live a fulfilling life outside of their caring responsbilities.

This focus is relfected in Surrey STP plans, as inequalities feature in the cases for change for each and in workstreams on prevention, cancer or mental health, or as in the Frimley Health and Care STP plan, as Priority Five: *Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence*.

AN INTEGRATED PLAN OF ACTION

Surrey's Better Care Fund plan 2017/18+ 2018/19 has been built on the foundations set in 2015/16 and 2016/17 – many of the schemes that were established last year will continue into the new plan. As mentioned earlier, we have learnt a great deal during year one and two of the Better Care Fund and partners have committed to accelerating and scaling up our work around integration – this plan, alongside the emerging STPs in Surrey, reflects that heightened ambition.

Surrey's approach is based upon local plans to meet specific local needs and system characteristics – it embraces a focus on people and place based solutions. Annexed to this plan are the local summary narrative plans – these, together with the CCG Operating Plans and the three Sustainability and Transformation Plans, set out the actions that each area will take to deliver integrated health and care services.

The BCF template also evidences local agreements, with detail in the expenditure plan. These have been agreed according to local guidance and using the governance process detailed above.

In Surrey we have created a single strategy through our Health and Wellbeing Strategy which has been aligned into each of the STP plans at a local level. Commissioning and planning continues at local, STP and Surrey level, using a principal of subsidiarity, which depends on the consistency in need, appropriate levels for intervention and the provider market. And we have agreed principles to ensure sustainability and equality when we make decisions locally at LJCGs.

An example is the H&WB prevention plan, which was built at the Surrey level and adapted to focus on local priorities at borough/district and CCG level, and later updated to reflect the Five Year Forward view and adapted by the three STPs for those footprints. We also have single strategies for Mental Health, Children and Young People and also Older People, which have been adapted into our three STPs.

Surrey level examples: Carers services continue to be commissioned at a countywide level, supported by years of established (and award-winning) joint commissioning, a committed Surrey-wide multi-partnership group, Surrey-wide providers and the desire for a consistent approach across the geography.

Local CCG level examples: the Epsom Health & Care Alliance arrangement in Surrey Downs CCG have built an integrated service to support older people and are already delivering improvements in accident and emergency waiting times, length of stay for unplanned hospital admissions and fewer delays in discharge from hospital. And in East Surrey, work is underway to set up a Multispecialty Community Provider (MCP) with broad buy-in from the local system to prototype solutions to locally identified priorities, like social isolation and diabetes.

STP level examples: the Surrey Heartlands partnership has evolved enough that the area has appointed a single Accountable Officer for all three CCGs, and to sign the Devolution Agreement highlighted above. This is only the second example of this nationally, following Greater Manchester, and devolution is viewed by us as an essential component to unlocking broader changes and accelerating our integration. It will allow for more effective collaboration in the Heartlands area, and the proposal to integrate health and social

care commissioning into a single function and budget will create new opportunities and strengthen partnership arrangements more than ever.

And in June it was announced that Frimley Health and Care STP (along with Heartlands), were included within the Accountable Care System (ACS) development programme, which involves all NHS organisations in a local area working together, and in partnership with local authorities to take collective responsibility for resources and population health.

At whichever footprint planning happens, plans are based on evidence (using resources like those highlighted above), monitored and evaluated, and they are jointly agreed.

Going beyond minimum contributions – Building on the integration success of the BCF and STP to date, there is a real appetite from system leaders to look for opportunities to integrate further and consolidate integration through frameworks beyond the BCF. These include Community Equipment, which is pooled in a separate arrangement, contributions to the MH Community Connections beyond the value funded through the BCF or the joint Surrey-wide approach to Safeguarding.

In 2016, system leaders attended a workshop event which produced an agreed set of 16 budget pooling principles, which has supported conversations in NW Surrey to pool all health and care budgets for older people, and will support this to be rolled out across Surrey. And funding commitments for Surrey Heath's Integrated Care Team (mentioned above) has gone well beyond BCF requirements, formalising the key role of social care in this integrated team, within a separate S75 agreement.

RISK MANAGEMENT AND RISK SHARING

Risk sharing for the Better Care Fund 2016/17 was clearly set out in the S75s between SCC and each of the CCGs. Within those agreements, partners acknowledge that there are two main risk types: shared partnership risks; and partner organisational risks associated with the move towards integrated working that are specific to each partner.

Each LJCG has developed and agreed its own local risk management arrangements associated with the delivery of local plans with each partner ensuring their own organisation's risk registers take full account of any organisation specific risks (financial and operational). In the example of any CCG being subject to financial directions, as has happened in the Surrey system, our risk sharing agreements allow reasonable decisions to be taken locally to manage anomalies. Our partnerships were proven strong enough to adjust our arrangements to best support the CCG and system.

We will build upon the existing risk sharing arrangements and progress the wider budget pooling principles that have been agreed

by the H&SCIB. In North West Surrey CCG and Surrey Heath CCG, progress regarding their shadow pools includes data sharing to identify where the risks (and savings) will materialise.

In line with the BCF national conditions and a local assessment of risk contingency allocations have been identified and agreed in some local agreements. These are set out in the BCF planning return template and are based upon an analysis of previous activity and local trends/forecasts. However there will be no decrease to the protection of out of hospital services.

Attached as an appendix to this plan is a Surrey wide risk plan, agreed by partners, which is monitored quarterly.

Risks are to some extent also mitigated through regular finance and performance monitoring at local level, and also at a countywide level, through groups like the BCF Metrics group.

PREVIOUS NATIONAL CONDITIONS

National condition: Delivery of seven-day services

Our CCG Operating Plans for 2017/18 + 2018/19 set out the overall approach to delivery of seven day services designed to prevent unnecessary non-elective admissions and 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 possible following an acute admission. Where seven day working is relevant to the High Impact Change Model, for supporting delayed discharges from hospital, this will be reflected in those local plans.

National condition: Better data sharing between health and social care, based on the NHS number

In 2015, a Commitment Statement to the secure, lawful and appropriate sharing of data to support better care, was signed by the Leaders of Surrey's acute hospitals, community providers, CCGs and local authorities at both tiers.

In support of this ambition, and in part fuelled by digital roadmap workstreams, significant work has been underway in Surrey over the past year, including imbedding the Surrey Information Governance Group (SIGG), and the current forming of a Strategic Information Governance Group, both key enablers for data sharing arrangements. Also underway is the development of integrated digital care records to support care joint planning further, and an integrated data platform using pseudonimised data to create new systems intelligence. Both would rely on the use of the NHS number as the common unique factor.

National condition: Joint approach to assessments and care planning

All areas are progressing their development against this previous national condition using local approaches, based on identified priorities and opportunities. These are detailed in local narrative plans. This will continue in East Surrey through the development of their MCP model, in Guildford & Waverley through the Proactive Care Service hubs, in North East Hampshire & Farnham through the Vanguard programme, in North West Surrey through the Model of Care, in Surrey Downs through the Surrey Downs Localities and in Surrey Heath through Integrated Care Teams

National condition: Consequential impact on providers

The current STP programmes in Surrey provide a much more structured and coherent set of forums for commissioners and providers to come together and discuss impacts, shape the market and build joint models. Of course this is in large part made possible due to the requirement for local provider engagement built into the BCF process, but the expectation will be that impacts on providers through integration planning can be more effectively managed than ever before.

NATIONAL CONDITION 2: NHS CONTRIBUTION TO SOCIAL CARE IS MAINTAINED IN LINE WITH INFLATION

The BCF planning Return sets out clearly the amounts of funding allocated to maintain provision of social care services and for the NHS contribution to adult social care at a local level to be increased by 1.79% and 1.9% in 2017/18 and in 2018/19 respectively. Agreements have been taken by LJCGs as part of their planning process, and the detail can be seen in the local narrative. The total invested in social care across Surrey is approximately £57m in the first year, and £58m in the second year

Even before the BCF policy framework confirmed the inflationary uplift to the contribution to maintain social care, discussions have already been underway at LJCG level to plan how this condition can be met. All partners are committed to continue this and are convinced of its value in securing stability for Surrey's health and social care system. The system has in fact responded by exceeding this commitment in a number of areas, as our system moves to ever closer integration.

Examples of schemes which Local Joint Commissioning Groups have agreed to fund in their areas, as part of the maintenance of social care, include carers voluntary sector grants and respite, community equipment, mental health Community Connections,

reablement teams, and also hospital social care teams (including seven day working). These services support the whole system; the hospital social care teams for instance have a huge role to play in ensuring people can return home from hospital as soon as possible. And a recent evaluation of the preventative Mental Health Community Connections has evidenced the positive impacts for individuals, but also for whole system demand. This service has now been brought entirely within the Better Care Fund, thereby increasing the budget amount, beyond minimum contributions, that is pooled for social care commissioned community services.

Comments on approach taken in setting ambitions for reablement and care home admissions metrics are included in the BCF planning template – Appendix 1

NATIONAL CONDITION 3: AGREEMENT TO INVEST IN NHS-COMMISSIONED OUT-OF-HOSPITAL SERVICES

The BCF planning template sets out clearly the amounts of funding invested in NHS commissioned out-of-hospital services. The total invested in NHS out-of-hospital services across Surrey is approximately £26m in the first year and £28m in the second year.

As with the protection of social care funding, partners in Surrey's health and care system are committed to continue to meet this condition or exceed it, as it's a key driver for our integration. For example virtual wards or various forms of integrated care teams funded through the BCF have brought together multidisciplinary practitioners around the person. And NHS rapid response services, which quickly respond to support need at home and prevent hospital admissions, is supported by social care reablement and night services. Local detail can be found in the local narrative.

There have not been additional targets set for Non Elective Admissions beyond those which the system is already working towards, and none of the funds required to meet this national condition of NHS commissioned out-of-hospital services have been held aside as contingency.

NATIONAL CONDITION 4 IMPLEMENTATION OF THE HIGH IMPACT CHANGE MODEL FOR MANAGING TRANSFERS OF CARE.

Surrey on a whole has better than average performance on Delayed Transfers of Care (DTOC), and despite increasing demands we have achieved a level of stability over recent years through the actions we have taken. This is evidenced if one looks at DTOC data over the full seven years that this data has been available. Between 2010/11 – 2011/12 Surrey's performance was behind the England average. However, action taken since then, including embedding social care teams at hospital sites and implementing 8am to 8pm working seven days a week, has enabled Surrey to outperform the England average.

Surrey is committed to continuous improvement in managing transfers of care, and can confirm that we are currently implementing many of the changes highlighted in the HIC model and have built local plans to address areas for development. To further this, Surrey has supported SE ADASS in measuring regional compliance against the HIC model, as part of its Regional Programme to improve ASC.

Supporting people home from hospital has however been a key feature of Surrey's BCF plan since before the HIC model was introduced, and has been a feature of integrated working in Surrey since before the introduction of the Better Care Fund. It is a corporate measure for the local authority as well as CCG partners, and is reflected in the Heath & Wellbeing Board Strategy, as well as STP plans. Surrey is also one of the south east region's first contributors of weekly data for a regional real time DTOC recording system, and is supporting regional analysis.

We have also collectively agreed to make use of the additional social care funding from the IBCF to best support our ambitions on supporting DTOC. As detailed in the BCF template and the IBCF Q1 reporting return, it has been jointly agreed to allocate the IBCF to funding new social care packages of care that support hospital discharge. This will also meet social care needs and help to stabilise the care market. The IBCF will represent a contribution to the estimated spend for these packages of care, but funding for the entire amount will be ringfenced. This approach allows the system to put the funding to use immediately and protects this vital area of spend against any potential in year savings requirements.

IBCF spend will be tracked against these intentions each quarter, and shared as part of the quarterly reporting to DCLG, NHSE and also to local A&E Delivery Boards.

Regarding the HIC model, it was felt that the picture will differ at local level, and that HIC plans will be implemented at that level, by LJCGs with local A&E Delivery Boards. However to support that, Surrey's H&SCIB held a discussion to compare the Surrey system, as a whole, against the model.

High Impact Change	Surrey-wide system comparison
1. Early Discharge Plan	Established – eg have Hospital Discharge Coordinators in place
2. Systems to Monitor Patient Flow	Mature – there are times and location where bottlenecks still occur, but this is the exception
3. Multi-Disciplinary/Multi-Agency Discharge Teams	This is not the same in each Acute system, so it was felt that three acute systems were Mature, and two were Established
4. Home First/Discharge to Access	Established – there is a particular challenge on timely care home assessments across the system. There is a project being initiated with providers to target this
5. Seven-Day Service	Established – though with very mature examples, like Epsom Health & Care Alliance. Key issues are seven day access to homecare, and access to the same level of decision making as during the week.
6. Trusted Assessors	Plans in place – there are trusted assessments between partners, but not trusted assessors yet. Work being undertaken to enable community providers to deliver assessments.
7. Focus on Choice	Mature – it was felt that this is consistent across the system
8. Enhancing Health in Care Homes	Established – admissions into hospital from care homes isn't managed equally across the system, but some areas, like East Surrey for example, are very mature

Please see the appendix for local HIC action plans and see the planning template for the agreed expenditure plan for the IBCF.

In an effort to achieve our ambitions on delayed transfers of care, we are satisfied that our IBCF joint expenditure agreement and local plans against the HIC model are giving Surrey the best possible opportunity to achieve that.

END – Surrey Better Care Fund plan 2017/18 + 2018/19