BETTER CARE FUND LOCAL NARRATIVE PLANS 2017-19

EAST SURREY

LOCAL ACTION PLAN 2017/18

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 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.

There have been some significant developments in the local partnership arrangements since our last submission, within the context of the 2017-19 NHS planning framework and the Sussex and East Surrey Sustainability and Transformation Plan. Prevention and the integration and coordination of care for people with the most complex needs are at the heart of the Central Sussex and East Surrey Alliance (CSESA) place-based plan. The vision for East Surrey is to work towards a multi-specialty community provider model in line with the ambition set out within the place-based plan, as part of a wider accountable care system based on the SASH footprint. During 2017/18, a key priority will be to lead the collaboration of the providers of care within the community to develop the model of care. In turn this will define the investment plan to deliver the shift envisaged in the STP and PBP from an acute hospital-centric model to a community based model, focused on prevention, self-management and coordinated care. This will include reviewing our existing investment in both primary care and community services, to align it to the new model.

Key partners including the GP Federation, First Community Health and Care and Surrey County Council are working closely with the CCG and wider partners to develop the MCP model, with a jointly established programme team and governance structure. As the statutory partners, the CCG and Surrey County Council continue to meet in the Local Joint Commissioning Group to make decisions about the BCF, joint priorities and local commissioning issues.

At the time of writing, the CCG is consulting its membership about the potential to join the Surrey Heartlands STP. Within the context described above, local discussions about more formal arrangements for progressing joint commissioning have not progressed further, as we would expect this to be part of any future arrangement across the Surrey Heartlands STP. The CCG continues to participate in the joint commissioning arrangements with other Surrey CCGs for mental health and children's services, as well as the other Surrey CCG collaborative arrangements.

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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.

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 2016/17

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

The Wellbeing Prescription (social prescribing) service continues to ensure that most practices have 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.

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). This scheme was re-tendered during 2016/17 led by Surrey County Council with the involvement of the CCG Mental Health Collaborative, with Richmond Fellowship reappointed as the provider for East Surrey.

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

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 opened in late March 2016 and is a collaboration between the CCG, voluntary sector, social care and secondary mental health services.

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

In 2016/17, the CCG focused on establishing networks of GP practices clustered geographically and covering populations of 30,000 - 50,000 delivering services together, putting primary care on an equal footing with the

other major providers and sitting at the centre of out of hospital care. The development of the networks is intended as an enabler to move funding from acute to primary and community care in line with the Five Year Forward View, placing an emphasis on prevention, self-care and community service provision. This transformation is necessary to reduce dependence on hospital-based services that can be both inappropriate and expensive while ensuring that primary care services are maintained for the future.

Systems for risk stratification in primary care and case management by Community Matrons are in place across East Surrey. Multidisciplinary team meetings were piloted and are now in established in three network areas. The plan for 2017/18 will be to embed and broaden these arrangements.

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. During 2016/17, arrangements were put in place to enable the majority of practices to share patient information via EMIS with community services.

Later in 2016/17 the focus was on putting in place the development of the building blocks for the MCP model across partners.

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

The Home from Hospital discharge scheme provided by British Red Cross at East Surrey Hospital is funded through the BCF. The scheme was retendered in 2016/17, and British Red Cross re-appointed for a further contract with Surrey County Council.

Life After Stroke Support is provided by the Stroke Association and funded through BCF. This service provides in-reach in to East Surrey Hospital, and follow up community support to stroke survivors, and their families, once they return home.

LOCAL ACTION PLAN FOR 2017/18

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. This year there will be a major expansion of the successful Wellbeing Prescription service, which will enable the service to work within all practices in East Surrey. Additional support will be available for larger practices and those with more deprived populations. Both councils are working closely with the CCG and wider partners on the development of new models of care for the MCP, and agreement has been reached to focus the efforts of the service on supporting the self-management and prevention elements of the pathway. This means, for example, that the Wellbeing Advisors will provide support to people with managing long-term conditions (eg diabetes and respiratory conditions), and will support people with severe mental illness to improve their physical health, addressing one of the biggest health inequalities in our local area.

Through BCF funding, local partners are also working with Altogether Better to provide support to eight GP practices to develop a collaborative practice model of care with their patients. Altogether Better is an NHS-hosted organisation that has developed a unique and specialist offer to support general practice in a new model to help their support patients.

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As the numbers of people with long term conditions in our communities grow, the model of general practice is struggling to meet the needs of the patient population which have shifted from requiring a relatively simple medical model (diagnose and treat) to one that includes social aspects that address issues such as personal motivation and skills for self-management, low level mental health needs, social isolation and the need to build community resilience and support. General practice is not currently designed to meet these needs but is experiencing high level of demand which it cannot meet as a result.

Altogether Better will work with practices to develop Practice Health Champions offering a range of activities within and around the practice. Evidence shows a significant reduction in demand for primary care and better health outcomes from practices participating in this work. As well as building resilience in local communities, by supporting practices to reduce demand and meet needs in other ways it will also free up general practice time to provide more support for people with long term conditions and complex needs.

As well as the expanded and new schemes described above, 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.

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.

As described above, during 2016/17 four geographically-based primary care networks were developed (Redhill and Merstham, North Tandridge, South Tandridge, and Reigate and Horley) to provide the building block for more integrated, coordinated care.

Further development of the model of care for people with complex needs, based on the networks, is a key focus for this year.

For the last three years the CCG has funded a Locally Commissioned Service (LCS) in primary care to supplement the national DES in the management of people with complex needs in the community. Utilising the nationally mandated £5 per head of practice population over 75 funding, the LCS has enhanced primary care in its role in coordinating complex case management, bringing together a true multidisciplinary team (MDT) approach to patient management ensuring that relevant patient health information is shared across the appropriate agencies. The aim of this service is to facilitate a consistent and coordinated approach to care, preventing unnecessary conveyances, and emergency admissions into secondary care, with care being delivered in the most appropriate setting.

Complex patients are identified through clinical assessment, supported by a risk stratification tool. Those identified patients then have a care plan developed with their GP that is accessible to the ambulance and out of hours primary care service. These patients are discussed at MDT meetings locally, within the practice, and escalated to the wider Network Complex Case Management MDT Meeting as necessary.

Within the LCS practices are also commissioned to provide care coordination to support the care planning process and the on-going coordination of the patient's care, working closely with the community provider.

During 2016/17 this LCS was revised to include an element of outcomes-based payment, to ensure focus was maintained on outcomes as well as the processes of cohort identification, care planning, and care

coordination. In 2017/18 this LCS is being further revised to consolidate the role of the primary care networks within our model of integrated care. This will include an enhancement of the care coordinator role to ensure a more consistent and equitable approach across the practices and primary care networks, providing extended access between 8am and 6pm Monday to Friday and support to network MDT meetings. This will be funded through BCF investment this year to provide a fundamental underpinning of the model for integrated care.

The network MDTs will also be bolstered by new roles working as part of a "Wellbeing Prescription Plus" service provided by Tandridge District Council. The service will work with people with multiple and complex needs to link them to voluntary and community resources. Working alongside the Community Matrons and wider network MDT arrangements, patients will be identified by the network MDTs and allocated to workers who will work closely with people to ensure their wider health and wellbeing needs are met. The programme will be managed and administered through the existing Wellbeing Prescription service to ensure a low-cost approach that benefit from the successful, local partnerships the service has developed.

As part of the development of the MCP, each of the four networks is also working on a "prototype", on areas agreed across the partners as being significant issues in East Surrey that would benefit from joint working to address. The prototypes are social isolation, falls prevention, end of life care, and the physical health of people with severe mental illness. A fifth prototype, diabetes, is being addressed by all the networks together. All local out of hospital partners are engaged in the work, which involves bringing staff together across organisational boundaries to work with patients and the public, examine evidence, and design and test new ways of working together to provide more effective, integrated services. The partners include the four main MCP partners (CCG, social care, community health and primary care), plus mental health, ambulance, public health, Tandridge District and Reigate and Banstead Borough Councils, Fire and Rescue, and St Catherine's Hospice. Plans to integrate mental and physical health services are being developed as part of this approach, with mental health engaged in many of the prototypes.

It is expected that the prototypes will develop during 2017/18 for full implementation across the patch (including any related additional commissioning) during 2018/19.

A further stream of work is developing the integration of social care reablement and community health rapid response services. Agreement has been reached to develop an integrated team with a single point of contact for both step-up and step-down elements of the pathway, responding to people in crisis in the community to prevent avoidable admissions and ensuring an effective response to those requiring discharge from an acute hospital. Integrating the service will ensure a more efficient and effective response, with the focus on ensuring the right health or social care professional responds in a timely way, and with "no wrong door" access into the service.

During 2017/18 further development of our successful nursing homes MDT will also take place. This will involve enhancing medical, pharmacy and specialist nursing support to reduce conveyances and admissions from care settings.

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, the Red Cross "Home from Hospital" service for people who might be vulnerable to readmission without short-term practical support, and the Life After Stroke Service for stroke survivors adjusting to the impact a stroke may have on their physical, social and emotional wellbeing. 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.

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Key elements of the CCG's plan for 2017/18 include the following developments designed to prevent unnecessary non-elective admissions and support timely discharge of patients from acute settings.

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 during 2017/18 our focus will be on developing a Wave 2 application for Core 24 development funding.

APPROACH FOR THE MANAGEMENT AND CONTROL OF BCF SCHEMES

The East Surrey Local Joint Commissioning Group (LJCG) manages and controls the schemes funded by the BCF. The LJCG meets monthly and its members include East Surrey CCG and east Surrey Adult Social Care. The LJCG reviews and evaluates reports for all the schemes and monitors performance of the schemes through the collection of appropriate data from the providers of the schemes.

The operational and performance aspects of the established hospital based integrated services are monitored through regular integrated steering groups, the Local Joint Commissioning Group (LJCG) and the Joint Executive Board (integration programmes).

The LJCG oversees the BCF grants and contracts, budget, and service delivery.

It is recognised that integration is in its early form and so benefit realisation is at its first phase. The local integration work plan will help drive forward integration and the potential benefit this can have on outcomes and system over 2017/2018 and beyond.

NATIONAL CONDITION TWO - NHS CONTRIBUTION TO SOCIAL CARE IS MAINTAINED IN LINE WITH INFLATION

East Surrey has agreed the BCF spend through the Surrey Health and Social Care Integration Board and the Local Joint Commissioning Group. The planned contributions to social care do not exceed the minimum and therefore the affordability criterion does not apply. There are no significant changes in the contribution to social care from the CCG.

The CCG is satisfied that the social care spend supports health through the provision of social care assessment, reablement and packages of care in the community that prevent avoidable hospital admissions, support discharge and keep people living independently in their local community.

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

A full description of the CCG investment in NHS commissioned out of hospital services is outlined in the attached narrative plan. The amount committed is equal to the minimum allocation. No additional target has been sent for non-elective admissions beyond that set with the CCG's Operating Plan and activity planning assumptions.

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

Please see Appendix 3

GUILDFORD & WAVERLEY

OUR LOCALITY PLAN

This section summarises the locality elements of the Surrey-wide BCF plan. It highlights:

- the links with our CCG Operation Plan for 2017/19 and the stakeholder and STP priorities for the Guildford and Waverley health and social care system;
- how we are meeting the national conditions within the local system; and
- how we will demonstrate that requirements around governance for the BCF and iBCF.

LINKS WITH OUR CCG OPERATIONAL PLAN

The Guildford and Waverley 2017-19 Operational Plan sets out the overall approach for meeting its statutory objectives for the delivery of healthcare services; meeting the needs of the local population whilst improving health outcomes and reducing health inequalities and delivering national performance standards from within its available financial resources.

The Guildford and Waverley healthcare system faces a significant and enduring financial challenge; with the background to this is set out in the Operational Plan. Our key pressures are due to demographic growth which is 4% compared with the 1.2% used for national planning assumptions and a 2% increase in our financial allocations for both 2017/18 and 2018/19.

In particular growths of 5.4%, 6.1% and 11.8% respectively in the 0-15, >65 and >85 age groups of our local population drives rising demand and costs because these groups have traditionally had the highest consumption of health and social care services. They are also at greatest risk of isolation and poor and or inadequately heated housing which can both impact on health and wellbeing. In real terms, this means the Guildford and Waverley health and social care system is likely to see an increase of over 3,000 residents aged 65 and above.

The combination of this demographic growth in the older adult population in combination with non-demographic growth in the prevalence of long term conditions such as hypertension, depression, asthma, coronary heart disease, stroke, diabetes and cancer presents a key challenge for health and social care system.

LINKS WITH STAKEHOLDER AND STP PRIORITIES

Analysis of Surrey's demographic and economic data and public services using Surrey-i and feedback from public engagement events held by the Local Authority have highlighted the importance of older peoples health locally and the health and wellbeing strategy for Surrey has identified this as a priority area for action.

The pooled commissioner funds within the 2017-19 Better Care Fund is enabling social and health care commissioners to work together, in conjunction with stakeholders, to commission integrated services which are effective in:

- preventing patients having unplanned or 'non-elective' admissions to hospital
- helping patients to remain in their normal place of residence for longer; and
- helping patients to return to their usual place of residence or to a suitable alternative place of residence, quickly after an unplanned attendance in urgent and emergency care departments or unplanned admissions to hospital.

Our Operational Plan identifies the actions we are taking locally and as part of surrey-wide sustainability and transformation partnership (STP) on prevention, health promotion, developing high quality and sustainable

primary care services in GP practices, developing consistent pathways and standards of care for those conditions which affect the most people locally and improving urgent and emergency care services.

The BCF plan is already contributing to the implementation of these strategies for example by supporting work on information governance and data sharing to support integrated planning and care deliver through shared health and care records; driving more responsive and sustainable equipment services and by supporting Telehealth and Telecare.

MEETING BCF REQUIREMENTS

In line with the four national conditions for the BCF[1] and our system priorities the main focus of our BCF plan is to provide targeted additional service capacity or capability for the urgent and emergency care system so that it is both responsive to patients and carers in crisis and supports people to stay in their usual place of residence for longer and / or to return to their home or a clinically appropriate residence in the community setting as soon as possible once clinically indicated; supported by a robust package of care.

The Guildford and Waverley CCG contribution to the Surrey BCF pool in 2017/18 is comprised of our CCG minimum contribution £11,698,190 and an additional contribution to pooled budget for integrated, social care commissioned community services. For 2018/19 the CCGs minimum contribution will be £11.92m. Growths in this investment are determined by the operational planning guidance to meet rising costs for services due to demographic growth. In addition to population growth government policies for a living wage are driving up costs across the adult social care workforce. Our social care partners have provided analysis for LJCG stakeholders to give assurance on how the BCF and iBCF can be deployed to address this.

A breakdown of our joint £13.99m investment is provided in the Better Care Fund 2017-19 planning template. All key requirements for investment in adult social care, NHS commissioned services, carers and responsibilities under the care act have been met as set out below.

- £4.342m investment to protected Adult social care covering:
    - re-ablebasement and carers services; keeping people at home for longer and avoiding non elective admissions
    - community equipment; helping people to return home and stay home by receiving the aids and adaptation they need to support independent living; and
    - hospital based Adult Social Care teams.
- £3.266m investment in NHS commissioned out of hospital or community services.
- £435K to support carers.
- £99K to support compliance with the Care Act.

The remaining joint pooled fund is being used to support local workstreams to reduce unplanned admissions and achieve local target for Delayed Transfers of Care (DTOC) using the high impact changes model.

1. Early discharge planning;
2. Monitoring patient flow;
3. Discharge to assess;
4. Trusted assessors;

[1] Condition 1: Plans to be locally agreed with plans signed off by Health and Wellbeing Boards and the constituent councils and CCGs; Condition 2: NHS contribution to adult social care to be maintained in line with inflation; Condition 3: Investment in NHS out of hospital (which can include 7 day and adult social care services and optional risk-share for excess activity) agreed; Condition 4: Managing transfers of care through implementation of the 8 high impact changes.

5. Multi-disciplinary discharge support;
6. Seven day services;
7. Focus on choice (early engagement with patients and their families/carers); and;
8. Enhancing health in care homes.

£478,000 and £1.303m from the BCF and iBCF are being used to on multidisciplinary / multi-agency discharge teams to support early assessment and intervention and enable the early planning of hospital discharges to Social Care.

Table 2 shows the relationship between the BCF plans the predominant high impact changes (2-4, 6-8).

TABLE 2

Workstreams supporting High Impact changes	Sum of 17/18 Budget£
7 day services	**£751,000**
Mental Health Community Connections	£308,000
Psychiatric Liaison Services	£296,000
Telecare	£107,000
Telehealth	£40,000
Discharge to Assess	**£354,207**
Homecare Service Provision	£354,207
Early discharge planning	**£324,000**
Community Equipment	£280,000
Handy Persons	£44,000
Enhancing health in care homes	**£169,000**
End of Life Care - Contract	£169,000
Multi disciplinary team discharge support	**£520,556**
Home from Hospital scheme	£49,000
Integration Costs	£119,556
Stroke Support	£20,000
Virgin Care Community Matrons and Nursing	£332,000
Trusted Assessors	**£233,000**
Interface Geriatricians	£233,000
Grand Total	**£2,351,763**

A summary of our plan for managing transfers of care, which is led by our Local A&E Delivery Board, is provided in the collated appendix of the Surrey wide BCF plan.

The CCG and Local Authority are members of the Local A&E Delivery Board (LAEDB) where they have been working in partnership with local providers and stakeholder members to agree this plan. This group provides the leadership and oversight for the development of the high impact changes plan.

The governance and chairing arrangements for the LAEDB have recently been revised and the group is now chaired by the Chief Executive of the local acute NHS Trust. Partners from across the health and social care system have used a range of stakeholder feedback including the findings from a series of service events to inform the priorities being taken forward to both sustain and support improvements in managing delayed transfers of care.

The Guildford and Waverley share of the additional £7.5m which will be available across Surrey from the new iBCF awarded in the spring budget which will be ring fenced to support improvements in the adult social care market supporting more people to be discharged from hospital once clinically indicated as fit for discharge.

GOVERNANCE AND SIGN OFF OF BCF PLANS

Governance and oversight of the BCF and iBCF is provided through the Joint Local Commissioning Group (JLCG); members will report on the elements of the high impact changes supported by the BCF to this group.

As a member of the JLCG the CCG supports the oversight this group provides in monitoring and evaluating the outcomes from the commissioners pooled fund and wider IBCF. The CCG plans to undertake further reviews of the health element of this investment with the BCF programme lead. We will evaluate and review how the resource can be deployed most effectively to reflect the role of the BCF as a boarder enabler of the integrated planning and delivery approach which will be developed by our STP during our shadow year of devolution.

The BCF has not identified any reductions in Non elective Admissions (NEAs) over and above those in the Guildford and Waverley Operational Plan. Therefore the local risk-sharing agreement, which has been agreed as a contingency in the event of excess activity, has been not been identified from the ring fenced CCG Hospital services spend in line with BCF guidance.

The CCG will present the local contribution to BCF plan for internal sign off by the Commissioning, Finance and Performance Committee. This committee and the governing body will review the full BCF submission for sign off prior to submission to the Surrey Health and Wellbeing Board on 7th September. This will enable us to meet condition 1; for plans to be locally agreed and signed off by Health and Wellbeing Boards and the constituent councils and CCGs, prior to submission to NHS England on 11th September.

NORTH EAST HAMPSHIRE & FARNHAM

2017/18 - 2018/19 STATEMENT

Integrated care is underpinned by our Primary and Acute Care System Vanguard – this continues 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. Building on our success in 2015/16 and 2016/17 - in which we developed our 5 integrated care teams – in 17/18 and 18/19 the focus for our new model of care will be on co-location for our 5 ICTs, increasing their caseloads by effective use of a risk stratification tool and increased clinical partnerships between primary and secondary care.

A COORDINATED AND INTEGRATED PLAN OF ACTION FOR DELIVERING THE VISION, SUPPORTED BY EVIDENCE

HAPPY, HEALTHY, AT HOME

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 whole population health approach considering the needs of our whole population and all of the assets that we have locally.

Expenditure plans for 2017/18 have been agreed by the Local Joint Integrated Commissioning Forum held between North East Hampshire & Farnham CCG and Surrey County Council. Over the past two years the group has agreed a number of shared commissioning decisions which following the completion of some service contracts has enabled joint investment decisions. An example of this is a new Social Care Team leader that

works as part of the Integrated Care Team in Farnham. The funding released elsewhere within the pooled budget has enabled this role to be expanded from part time to full time in 2017/18.

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.

Our vision of our model of care is made up of 4 core component parts:

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

During the first two years of the Vanguard programme, a number of schemes have been piloted and this year our focus is on turning good work into hard-edged delivery.

In January of 2017 we ran a process to determine where 2017/18 funding would be best placed and also looked at how we reduced infrastructure costs to support more clinical services.

This resulted in nine programmes which are being supported in 2017/18. Monthly monitoring against the impact plans by programme is in place and is overseen by the Vanguard Steering Group and shadow ACS board.

WHAT WE ARE DELIVERING: PREVENTION AND SELF-CARE

MAKING CONNECTIONS

This service is run by a voluntary organisation and offers help to people in need of non-clinical support and enables individuals to be proactive in managing their own health and wellbeing.

Examples of support offered in the service:

- Nepalese woman in her 50s living in inappropriate housing for her disability
- A 26 year old autistic man with mental health issues who has low self esteem

Early and caveated findings from evaluation of the service are showing:

- A reduction in the rate of A&E attendance of 18%
- A reduction in the rate of emergency admission of 19%

The service works closely with the integrated care teams and is represented at multi-disciplinary team meetings.

RECOVERY COLLEGE

Operating since April 2016 the College enables carers and staff to better understand mental health and supports people on their journey to recovery so they become experts in their own self-care.

On offer is a range of educational workshops and courses to help people understand their experiences and gain the knowledge they need to take control of their personal recovery journey. Courses are prepared and delivered by people who use services in partnership with staff and there are opportunities for progression from volunteering to paid trainer roles.

All students graduate with a certificate of success and they are encouraged to seek further opportunities

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WHAT WE ARE DELIVERING: NEW WAYS OF WORKING

MISSION

A series of clinics delivered in a community setting for patients with a respiratory condition. Secondary care respiratory specialists lead the clinics and educate/mentor staff within the primary care setting to identify, treat and manage patients with respiratory conditions.

Successfully piloted in September 2016 MISSION is based on a model previously proven to significantly reduce healthcare utilisation costs, recognising that the long wait that patients often endure to receive specialist care impacts on all aspects of their lives, often leads to poorer outcomes.

EMERGENCY SEVERITY INDEX

The model optimises flow through the acute provider's emergency department (ED) using a tool called the Emergency Severity Index (ESI) to support decision-making on pathways through the ED for a specific patient group (ESI3). The pilot produced early results of a reduction in breaches for ESI3 patients; demonstrated improved outcomes and had a positive knock on effect on activity in other flows.

Due to the model's success at Frimley Park it is now being rolled out to other parts of the system.

NHS 111 TRIAGE AND PRESCRIBING PHARMACIST

NHS 111 triage, an out of hours service, eases pressure at the 'front door' by dealing with pre-agreed 111 dispositions**.** The service decreases inappropriate referrals to the emergency department releasing pressure and improves patient satisfaction as the patient is treated in the most appropriate setting for them.

Another out of hours service is the prescribing pharmacist whose primary role is to speak to patients where the information from NHS111 or initial nurse triage indicates that medication information or a prescription is required. Secondary to this the Pharmacist assists with cases which are suitable for self-care advice such as colds and earache which a Pharmacist is used to handling in the Pharmacy environment. This increases the range of health care professionals available within the call center in line with proposed future models of care and eases pressure on a doctor's time

ENHANCED RECOVERY AND SUPPORT AT HOME

Enhanced Recovery and Support at Home brought together existing services which became an integral part of the vanguard programme in April 2016 enabling it to expand. Where it is possible and medically appropriate, the model supports patients with urgent, acute and/or complex care needs, enabling them to regain the confidence to be at home self-managing their condition. This service provides support to two distinct cohorts of patients:

1. Those experiencing a crisis within the community, but not requiring an admission into an acute hospital.
2. Those requiring a supported discharge from acute or post-care with identifiable rehabilitation or recovery needs.

Care is delivered through collaboration with local health and social care partners so that services are designed around patients, resulting in frail and older people living healthier, more independent lives.

WHAT WE ARE DELIVERING – CARE CLOSER TO HOME

LOCALITIES

The localities work to release GP time to help patients with complex health needs; to support patients in the community and reduce attendance at the emergency department. Examples from across the system in support of this are:

- Centres offering on-the-day GP appointments. Patients contact their GP surgery in the usual way and a triage system is in operation to allot a same-day appointment where needed.
- GP peer review of referrals. This is leading to lower utilisation of secondary care; showing a potential return on investment of redirected referrals of 97%
- Paramedic Practitioners are supporting a Rapid Home Visiting Service
- Integrated care teams operating in all five localities providing support to people with complex health and social care needs. Increasingly the teams are focussing on working with patients pro-actively to prevent them needing urgent care services.

WHAT WE ARE DELIVERING – FUNCTIONS TO SUPPORT DELIVERY

20/20 LEADERSHIP PROGRAMME

A leadership programme improving the quality of local healthcare through better identification of community needs and an inter-connected approach to solving these. Cohort 1 is nearing completion of the programme and plans for cohort 2 are underway.

INFRASTRUCTURE

This includes the resources and workstreams which support delivery of the Vanguard projects and includes IT, Estates, Communication and Engagement and the Programme Management Office function.

EVALUATION

Evaluation of our work helps us to share best practice across the system and the wider service. It also informs future commissioning. Our evaluation work is conducted by the Academic Health Science Network. We have a monthly dashboard which looks at performance of the system and the impact/benefits realised as a result.

ACCOUNTABLE CARE SYSTEM

The population of North East Hampshire and Farnham are part of the Frimley Health Accountable Care System (ACS). The ACS Board began meeting in September 2016 and their responsibilities are to:

a) Develop, agree and oversee the delivery of a strategic plan for the North East Hampshire and Farnham health and care system;
b) Take collective responsibility for the health of, and health and care services for the registered population (including mental health, primary, community and acute care, and social care);
c) Manage the available funding for the population of North East Hampshire and Farnham, committing to shared performance goals and deploying the shared workforce and facilities to meet the needs of the population.

The Frimley Health ACS is among the first eight designated ACSs in England announced in June 2017. ACSs will build on the learning from and early results of NHS England's new care model 'vanguards'.

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NHS CONTRIBUTION TO SOCIAL CARE IS MAINTAINED IN LINE WITH INFLATION

We have confidence in our planned contributions to social care spend from the BCF and this will be spent on social care services that have some health benefit and support the overall aims of the plan.

AGREEMENT TO INVEST IN NHS-COMMISSIONED OUT-OF-HOSPITAL SERVICES

System wide activity plans have been agreed as part of the Happy, Healthy, at Home Vanguard programme. The Better Care fund compliments these plans but does not look to make further reductions in non-elective admissions.

IMPLEMENTATION OF THE HIGH IMPACT CHANGE MODEL FOR MANAGING TRANSFERS OF CARE

The overall aim of the Frimley Health & Care STP is to work in partnership with our population and local partner stakeholder organisations to provide an integrated health & social care system fit for the future. This means people receiving / having access to seamless holistic services that meet their physical and mental health needs at the earliest possible opportunity – right care, right time and right place. Through focus on the individual, as opposed to structure, there is increased focus on prevention and pro-active care rather than reactive treatment.

As a Frimley system the current DTOC performance levels are only marginally off the national target of 3.5% and as an STP we have focused on agreeing a Trust wide trajectory for improvement which all partner organisations have signed up to.

Our Frimley STP Delivery Plan ambition is to meet the 3.5% DTOC target by March 18 and to continue to meet it thereafter.

The Frimley STP Urgent and Emergency Care Delivery Plan follows the seven pillars as set out in the national plan, namely:

1. NHS 111 Online
2. NHS 111 Calls
3. GP Access
4. Urgent Treatment Centre
5. Ambulance
6. Hospitals
7. Hospital to Home

The Hospital to Home action plan specifically focusses on the High Impact Changes and is attached for reference. The plan outlines the high level actions being implemented and further work continues on developing and implementing the more detailed local actions.

NORTH WEST SURREY

A COORDINATED AND INTEGRATED PLAN OF ACTION

As per usual practice, North West Surrey CCG's Operational Plan 2017-19 was signed off by Surrey's Health and Wellbeing Board to ensure alignment between local and countywide priorities and vision. The key priorities and principles from this plan around Health and Social Care integration are:

Key priorities:

- Agreement to invest in NHS commissioned out of hospital services
- Agreement of a local target for Delayed Transfers of Care (DTOC)
- Development of a local plan supporting reductions in unplanned admissions and Delayed Transfers of Care

North West Surrey system is committed to ongoing investment in social care as part of delivering the key priorities.

Principles:

- Single model of operational management and delivery; minimising duplication and improving efficiency
- Core, integrated teams focussed around clusters of GP practices
- Higher level of generalist skill across community nursing, capable of managing multiple co morbidities
- Interoperability with primary care systems and streamlined, efficient referrals and information sharing
- Use of named staff to coordinate seamless and timely access to different services
- Access to a range of specialists for advice, education and clinical support in the most complex of cases

During 2017/19, we will continue the implementation of our Model of Care which is designed to ensure that the needs of people are at the centre of decision making and service redesign. The Model sees shifts in the setting of care provided and improvements in the way in which we work as a system. Integral to the Model of Care are a number of fundamental design principles: people-centred integration of health and care services; whole system care navigation; sustainability of our Acute Trust; mental health equality; provide care at the most appropriate place; age-appropriate care; transition of Children and Young People into adult services.

Through the newly procured Adult Community Services Contract we have a range of community health services primarily for adults aged 18 years 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. It provides the platform to embed service integration more fully into our "business as usual". Key elements include our integrated discharge pathway, around the acute hospital, our locality Hubs and primary care transformation plans.

Further information is available in North West Surrey CCG's Operational Plan 2017-19 at:
http://www.nwsurreyccg.nhs.uk/about-us/Pages/Our-plans.aspx

A BCF finance schedule has been agreed between commissioners, executives and finance leads in both organisations which will direct two years of BCF funding towards services which can have the greatest impact on the delivery of the vision within this narrative. Funded schemes fit into four categories: maintaining social care spend in areas that direct people away from hospital either before admission or upon discharge, maintaining health spend in out of hospital services, enhancing this spend in both social care and health areas through jointly commissioned services, and supporting housing services in the District and Boroughs through incorporation of DFG into BCF plans along with additional funding for Housing Services. Services which are jointly invested in include preventative services such as information and advice and mental health Community

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Connections. There is also a focus on support to return from hospital and remain at home independently through the Home from Hospital service, telecare, community equipment and handyperson services.

The Senior Operational Group (SOG) focusses on the operational delivery of service transformation and improvement. The SOG is made up of senior representatives from NW Surrey CCG, Primary Care, Adult Social Care, Surrey & Borders Partnership NHS Foundation Trust, Ashford & St Peter's Hospitals NHS Foundation Trust (ASPH) and Central Surrey Health (CSH) Surrey. The SOG will oversee and manage a number of relevant sub-groups in priority areas in order to deliver the detailed, operational design of services and enact genuine changes in practice. It will ensure timely delivery and benefits realisation against key plans, and collectively hold members to account for delivering agreed actions.

Identified key priority areas, which enable the North West Surrey system to deliver the Better Care Fund objectives, are:

1. The redesign and reconfiguration of 'front door' urgent care services
    - Plans to redevelop ASPH A&E and Urgent Care Centre
    - Review of system services which support delivery of this priority

2. The expansion and development of the Locality Hubs
    - Building on the model established in Woking and delivering at planned scale for 5000 people, including implementation of a reactive service
    - Hub services to be expanded to Thames Medical & SASSE Localities

3. The development of an Integrated Discharge Pathway across the system
    - The Integrated Care Bureau (ICB) was established in September 2016 to enable delivery of the 3 pathways which ensures:
        a. no decision about long term care is taken in an acute setting
        b. Minimise hospital length of stay whilst maximising independence
        c. Provide care at home wherever possible
        d. Improve patient outcomes at each part of the acute urgent care pathway
        e. Effectively planning and supporting safe discharge and preventing readmission
    - Continued development of the ICB including the evolution of the service model, developing strong operational processes and effective integration with locality hubs, which includes full delivery of trusted assessment across the system

The Group also has responsibility for the design of services in accordance with the strategic direction set by the NW Surrey Cabinet and key strategic developments across the North West Surrey system e.g. the development of a Provider Alliance and the mobilisation of the new community services contract. It is also responsible for evidence based development, management and oversight of implementation plans to ensure service change and transformation is practically achieved at the required pace and with the buy in of all key partners.

The locality Hubs are part of the Future Hospitals Programme, one of eight selected development sites, feeding back nationally and part of a national evaluation publication due later this year. As part of Phase 2, the North West Surrey Hubs are one of four sites that are focused on providing person-centred care across integrated healthcare services.

The Integrated Discharge Pathway will be linking into regional work led by Kent, Surrey and Sussex Academic Health Science Network across the STP footprint and wider – the Safe Discharges and Transfers project. This will enable a co-ordinated but local approach.

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

Contributions to Social Care outcomes have been increased by 7.2% through both additional funding to Adults Social Care by the CCG, and through increased BCF funding into CCG services which have primarily social care outcomes. This frontloads the 2 years' inflationary increase into the 17/18 plans, and is affordable due to part use of BCF funds from decommissioned services. The additional funding is supporting services which add to both the Health and Social Care elements of the vision for Better Care Fund and so focusing funding here will not destabilise the system as a whole.

The social care spend supports health through the provision of social care assessment, reablement and packages of care in the community that prevent avoidable hospital admissions, support discharge and keep people living independently in their local community. These also support 7 day working.

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

The expenditure plans shows an increase in the funding from previous years in NHS out of hospital services. There is no additional target for NEAs, and no contingency linked to this.

The CCG has sourced a radically different and improved out of hospital care provision including the new community services contract with the following elements:

- Blurring the boundaries between primary care and community services building strong day to day working relationships between community teams and GP practices
- Development of core, integrated teams focussed around clusters of GP practices and working directly with primary care professionals on a day to day basis
- Robust care coordination and the use of named staff to coordinate seamless and timely access to different parts of community services, mental health services, the voluntary sector and social care
- The development of a much higher level of generalist skill, including high quality self-management support, across community nursing capable of managing multiple comorbidities rather than an overreliance on specialist teams to manage a single condition
- A single point of access for referral and telephone contact; shared IM&T systems and information governance processes and development of innovative use of technology to deliver care such as Telehealth.
- Interoperability with primary care systems and streamlined, efficient methods of referral and information sharing; particularly important is the ability to provide direct interoperability with the prevailing clinical system in North West Surrey, which for the vast majority of practices is EMIS.
- A service that responds to the needs of the patient or their carer with regards to response times and operating hours.

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

Local A&E Delivery Board are engaged with the plan. The BCF plan supports the wider joint agenda to promote a seamless pathway so that people are not delayed for discharge and admission. There are established positive joint working arrangements in North West Surrey across the system. There are structures around planning for discharge for medically stable people with a daily system call.

Please see Appendix 3

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WINDSOR ASCOT & MAIDENHEAD CCG

A small part of NHS Windsor Ascot and Maidenhead CCG's footprint is in North West Surrey – the Surrey BCF expenditure plan (annex 1 to this plan) shows the agreed scheme level spending plan for this area.

NHS Windsor Ascot and Maidenhead CCG Strategic Commissioning Plan sets out the CCGs ambitions for the next five years. The realisation of these ambitions will only be possible through working with our partners to improve the overall health and wellbeing of our local population. The vision of integrated care is described in the following commitment to our patients:

"In Windsor, Ascot and Maidenhead you will be supported to be active in a safe and caring community allowing you to live a fulfilled life as independently at home for as long possible. When you need care you will only have to tell your story once. You will have access to information and services that guide you to make the right choices for you about services."

From the 2014 – 2018 five year strategic commissioning plan, WAM CCG sets out its ambition for an integrated system that is sustainable for the future with improved outcomes for local people enabled via the Better Care Fund, this will result in:

- Care led by the person and involving their family and carers - conversations should always start with 'what is important to you' and services will come to people
- Older people continuing to feel part of a community and providing them with opportunities to 'give back' their time and skills, thus promoting mental wellbeing and enabling them to live a full life
- Socially isolated people will be encouraged to become more active with a supportive community which reaches out to them
- Promoting understanding and the development of a caring community through cross-generational activities
- Promoting the use of technology to support families, carers and care professionals to work together effectively
- One person who will work with people to understand their choices
- Supporting older people to remain active, age well and remain fitter for longer through the use of a range of leisure facilities and community events and networks, developed with the needs and wishes of older people in service planning
- Having a comprehensive and responsive spectrum of care available, which does not rely solely on institutional care
- Recognising everyone desires to be as independent as possible and we will do all we can to support that wherever individuals live
- General practice is firmly placed at the heart of local services, directing a range of community and social care services

SURREY DOWNS

A COORDINATED AND INTEGRATED PLAN OF ACTION FOR DELIVERING THE VISION, SUPPORTED BY EVIDENCE

Surrey Health and Wellbeing Strategy support the following priorities of

1. Improving children's health and wellbeing
2. Developing a preventative approach
3. Promoting emotional wellbeing and mental health
4. Improving older adults' health and wellbeing
5. Safeguarding the population

Surrey Downs, aligned to the Surrey Heartland Sustainability Partnership have six clinical priorities of

1. Mental Health
2. Dementia
3. Learning disabilities
4. Maternity
5. Cancer
6. Diabetes

Surrey Downs CCG has a clear vision for the development of comprehensive health and care provision for the local population. The aspiration is to achieve provision of integrated locality based models of care wherever possible and services which support economy of scale as necessary.

Central to this vision is the development of excellent integrated and aligned community services, working in collaboration with primary care, to provide a holistic care response genuinely tailored to the needs of the individual. The realisation of this level of integrated care will develop alongside the evolution of the local care economy and changing national landscape, and the need for greater interoperability, sharing of information and a focus on overall individual outcomes.

Providers and commissioners have come together across Surrey Downs Localities to develop long-term models of care that will be implemented over the next five years – these focus on providing pro-active and preventative care to stop people becoming unwell in the first place. When deterioration is unavoidable, these models aim to create integrated, multi-disciplinary services delivered in the home and in the community to prevent hospital admissions (and get people home from hospital quickly). The following local **principles** support this vision:

- Reduced complexity of services
- Wrap multi-professional services around primary care supported by the emerging design of multi-specialist providers
- Multidisciplinary teams providing care for people with complex needs
- Supporting community teams with specialist medical input
- Create services that offer an alternative to hospital stay
- Have an infrastructure to support the clinical model, including better ways to measure outcomes and work together to enable seamless assessment
- Develop capabilities to harness the power of the wider community

Surrey Downs CCG and the Local Joint Commissioning Group, has taken a locality level approach to delivering Health & Social Care integration supported by aligned outcomes. The Surrey Downs area has three distinct localities (Epsom, East Elmbridge and Dorking) flowing into three Acute Trusts of Epsom and St Hellier Acute

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Trust, Surrey and Sussex Hospital and Kingston Hospital. Each locality is developing and maturing an integration delivery approach reflecting local challenges and priorities including:

- Community Medical Teams (CMTs) run by local GP networks, leading community based crisis response, managing local community hospital beds and acting as the fulcrum of the model of care
- Community Hubs including statutory (health and social care) and voluntary services working with CMTs to manage a case load of high risk individuals identified through acute exacerbations and risk stratification.
- Provision of enhanced multi-disciplinary support to prevent admission to hospital and provide early supported discharge.

EPSOM LOCALITY

Providers and commissioners have come together under a formal provider alliance to develop a long-term care model. Phase 1 is primarily a reactive model, focused on developing a suite of services as part of Epsom @ home and phase 2, which is currently underway, expands the model by taking a whole population approach focusing on providing pro-active, preventative care to stop people becoming unwell.

EAST ELMBRIDGE AND DORKING LOCALITIES

East Elmbridge and Dorking Localities also operate community medical teams and work together with the wider community team consisting of identified community matrons, therapy and reablement staff with provision by the locality GP federations.

BCF CONTRIBUTIONS

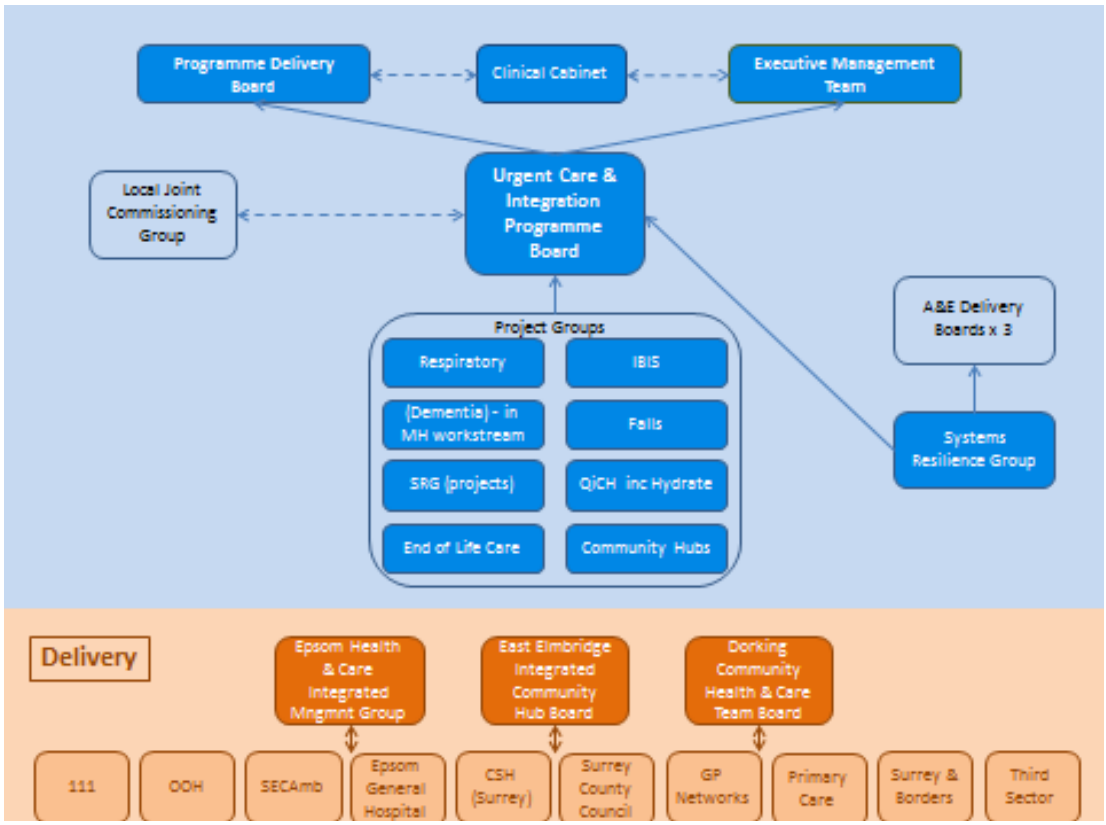
Social care contributions have increased by 7.2% supporting social care outcomes. Services that are being commissioned supporting joint principles identified in the local vision and Better Care Fund ensuring that the funding does not destabilise the system. Investment shows an increase in funding from previous years.

Surrey Downs have agreed the BCF budget through the Surrey Integration Health Board and the Local Joint Commissioning Group. Primarily schemes supported by the BCF budget will be those which support integration and align to the strategic priorities above. It has been agreed that a BCF integration contingency fund will be used to support system resilience 2017/ 2018 with a focus on supporting acute flow**.** Investment in local services also aims to support home from hospital and prevention of admission, including mental health.

The BCF also directly funds and supports the social care reablement staff and the hospital team which is key in supporting early supported discharge enabling 7 day working where appropriate.

GOVERNANCE

The Local Joint Commissioning Group is supported by the following governance structure including social care representation:



NATIONAL CONDITION TWO - NHS CONTRIBUTION TO SOCIAL CARE IS MAINTAINED IN LINE WITH INFLATION

A wide range of initiatives sit within the BCF plan and robust programme methodology and governance structures (via the Local Joint Commissioning Group and Integration Programme Board) are in place to oversee delivery, performance and benefit realisation of the BCF related plans and schemes.

An integrated care dashboard and risk log is produced and reviewed on a monthly basis to monitor performance , track schemes and project milestones and identify risks and mitigating actions.

Project groups or in the case of the local integrated care models – Integrated Delivery Boards have been established to track progress against plans and these report into the LJCG and/or Integration Programme Board. In addition regular in depth evaluations are conducted against each of the integrated models

Evidence base, review of best practice and local need and priorities are considered when identifying and considering new schemes or initiatives.

The LJCG reviews existing schemes on a regular basis and where appropriate providers are invited to the LJCG to share progress. Where schemes are not delivering the required benefits or meeting the local priorities integrated decision made me made to decommission the scheme

Surrey Downs and SCC have agreed the BCF budget through the county Integration Health Board and the Local Joint Commissioning Group. The Chief Finance Officers are part of the LJCG and involved in the decision making process and in ensuring services are affordable

It has been agreed that there is an integration contingency fund (104K) and spend against this fund will be jointly agreed and considered against criteria such as supporting the whole system/ transforming care and meeting local need and priorities.

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Examples of Investment in local services include supporting 'home from hospital' services and rolling out social prescribing models.

The BCF also directly funds and supports the social care reablement staff and the hospital team which is key in supporting early supported discharge. Both these services work 7 days a week and are integrated into the local integration models

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

As with the agreed plan to meet the condition on protecting Social Care, Surrey Downs Local Joint Commissioning Group have agree to meet the full minimum contribution to protecting out of hospital services. No additional targets have been set for Non Elective Admissions, and no funds are held back from the minimum allocation as contingency against these targets.

An example of one of schemes supported through this contribution is Surrey Downs' Home from Hospital Service (currently local providers -Home Group).

This service which is designed both to help avoid unnecessary admission to hospital and facilitate discharge, offers short term, low level support to people who are medically fit for discharge (from hospital/A&E). Types of support include escort home or meet and greet, settling in, reassurance, befriending and confidence building visits, loan of small items of equipment, shopping, transport/escort to hospital appointments/GP visits, signposting, telephone support and check in.

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

Please see Appendix 3

SURREY HEATH

LOCAL BCF PRIORITIES

Surrey Heath's Better Care Fund plan 2017/18 and 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. The local plan will provide details on how the local integrated BCF will deliver the following priorities:

1. Protection of Social care
2. Protection of Out of Hospital Services
3. High Impact Change Model for Managing Transfers of Care

Our local BCF planning assumptions are based on evidence of population needs from the Surrey Joint Strategic Needs Assessment and designed to deliver the requirements of the national BCF metrics.

Social care and community health services already work across the Surrey Heath 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 2017-19 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 rapid response 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

ALIGNMENT TO SYSTEM WIDE PLANS

The local Surrey Heath BCF Plan provides assurance to the Surrey Health & Wellbeing Board that the initiatives contribute towards the delivery of the aims and objectives in the Surrey Heath & Wellbeing strategy. Our BCF Plan aligns with the delivery plans associated with our Frimley Health & Care Sustainability Partnership (STP). The STP workstream priorities include the following initiatives that will strengthen integration across health and social care systems:

PREVENTION & SELF CARE:

To ensure people have the skills, confidence and support ***to take responsibility for their own health and wellbeing****.*

INTEGRATED DECISION MAKING HUBS:

To develop ***integrated decision making hubs*** *to provide single points of access to services such as rapid response and reablement, phased by 2018.*

THE SOCIAL CARE MARKET:

To transform ***the social care support market*** *including a comprehensive capacity and demand analysis and market management*.

SUPPORT WORKFORCE:

To design a ***support workforce*** *that is fit for purpose across the system*

SHARED CARE RECORD:

To implement a ***shared care record*** *that is accessible to professionals across the STP footprint.*

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GOVERNANCE ARRANGEMENTS

The governance arrangements to manage and monitor the schemes included in the local BCF Plan are managed on an operational basis by the Surrey Heath Local Joint Delivery Group (LJDG). The membership of the LJDG is made up of Senior Managers from the CCG and the Adult Social Care Locality Team. The LJDG reports progress against the schemes and budgetary position of the pooled budget to the Local Joint Commissioning Group (LJCG) on a monthly basis. This includes identification of underperforming areas and mitigation actions to rectify issues.

The LJCG membership includes Executive Directors from the CCG and Surrey County Council and provides oversight and assurance that the plan is delivering joint benefits for the population of Surrey Heath.

The LJCG reports to the Surrey Health & Social Care Integration Board (H&SCIB) which is made up of Executive level members from all Surrey CCGs and Surrey County Council. Members of the H&SCIB identify areas of good practice and share learning across local health and social care systems. It also provides oversight and assurance to the Surrey Health & Wellbeing Board that the Surrey wide BCF Plan is collectively delivering population benefits.

FINANCIAL ARRANGEMENTS

For 2017/18 the Surrey Better Care Fund totals £87.1m, of which £6.9m is allocated to the Surrey Heath LJCG. This includes the Improved BCF and Spring Funding of £0.6m. The CCG contribution is £5.627m

This investment is further broken down into areas of spend which are either solely commissioned by Surrey County Council (SCC) as the local authority or by Surrey Heath CCG, or jointly commissioned.

The areas of spend which are examined by this overview are highlighted in green in the table below:

BCF Summary Category	**17/18 Budget £000**
Protection of Adult Social Care Total	2,032
Health Commissioned Services Total	1,468
Continuing Investment in Health and Social Care - CCG managed Schemes Total	827
Continuing Investment in Health and Social Care - SCC Total	883
Care Act Revenue Total	212
Carers Total	204
BCF Plan Submission Total	**5,627**
Disabled Facilities Grant	**661**
Improved BCF and Spring Funding	**613**
Grand Total	**6,900**

PROTECTION OF SOCIAL CARE

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 local 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.

PROTECTION OF OUT OF HOSPITAL SERVICES

The Integrated Care teams in Surrey Heath have been functioning since April 2015 and during 2016/17 Social Care Locality Staff have been fully integrated into the existing teams and the Single Point of Access (SPA) within Surrey Heath. The Integrated Care teams are the focal point for joint assessment and care planning for those in the population most at risk of non-elective admission or to facilitate discharge. This multi-disciplinary approach is applied to care planning and supporting self-management through the Community Teams, General Practice and Voluntary Organisations. The planned actions for this team are:

- 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. The identification of patients for joint assessment and care planning is underway and the potential for a trusted assessor model is being reviewed.
- 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.
- Inclusion of social care referrals from professionals into the existing SPA. This will further enable the joint approach to care planning and assessment as well as proactively identify people who could benefit from health related support.
- Comprehensive work is underway to further integrated health and social care through Rapid response services and reablement services now working together to improve the cooperation and coordination of the delivery of care, care planning and assessment. Use of standard assessment form and coordination of assessment. This will also influence the procurement of future community services.
- 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.
- Sharing of information and care plans across providers, where appropriate and of benefit. Care plans to be available to the Ambulance Service, Out of Hours GPs and Acute provider in Q1.
- *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.

HIGH IMPACT CHANGE MODEL

Please see Appendix 3

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