# Surrey Better Care Fund 2016/17

**May 2016**

**Version: FINAL**

# This plan has been signed off on behalf of their organisations by:

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David Eyre-Brook, Clinical Chair, Guildford & Waverley CCG and Health and Wellbeing Board Co-chair

# structure of our plan

# introduction

The Surrey Better Care Fund plan 2016/17 builds on the progress made in 2015/16 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
- Surrey County Council
- NHS Surrey Downs Clinical Commissioning Group
- NHS Surrey Heath Clinical Commissioning Group
- NHS Windsor, Ascot & Maidenhead Clinical Commissioning Group

Surrey is one of, if not the most, complex health and care systems in the country. Surrey has 1 county council, 7 clinical commissioning groups, 11 district and borough councils, 5 acute hospital trusts, 1 mental health Trust, 3 community care providers and 129 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.

The next five years will be exceptionally challenging – an ageing population, increasing demands on services and our collective financial pressures necessitate a radical shift in the way services are delivered. This plan, as part of an emerging suite of strategy documents, demonstrates how we will work together to deliver better outcomes for the residents of Surrey whilst meeting those challenges.

**The 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. 2016/17 is the second year of the Better Care Fund programme.**

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

Surrey Better Care Fund Plan 2015/16
Clinical Commissioning Group Operating plans 2016/17
Surrey County Council Corporate Strategy 2016-2021
Surrey County Council Medium Term Financial Plan 2016-2021
North East Hampshire & Farnham Vanguard documentation
CCG Operational Resilience and Capacity Plans
Epsom Health and Care Integrated Business Case 2016/17 and 2017/18

This plan has been developed alongside the emerging Sustainability and Transformation Plans (STP) covering Surrey:

Surrey Heartlands STP
Sussex and East Surrey STP
Frimley Health STP

The plan has also been developed alongside the emerging digital roadmaps (see national conditions section).

# learning from the better care fund 2015/16

Better Care Fund 2015/16 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 the 2015/16 plans, negotiating and agreeing governance arrangements, and through the implementation of our plans.

Our local joint commissioning arrangements have enabled us to share and use our learning to inform local plans and actions throughout 2015/16, 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 through updates and discussions at the Surrey Health and Wellbeing Board and the scrutiny and challenge provided by the County Council's wellbeing and health, and social care services scrutiny boards. 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.

In reviewing BCF 2015/16, 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;
- relationships between partners and joined up working across Surrey have grown stronger through 2015/16 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; and
- 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.

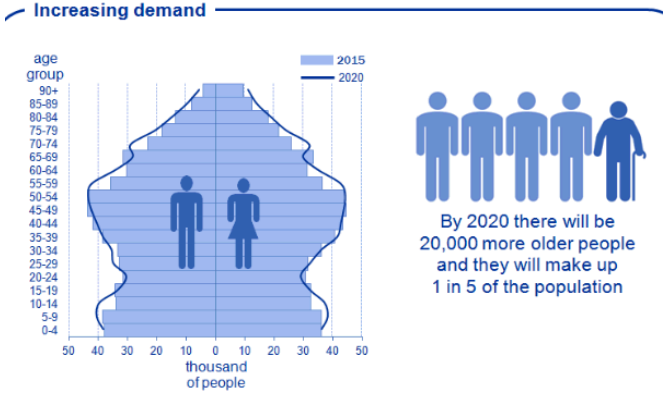
We've also identified areas where we'll need to maintain or place added focus in 2016/17 – these reflect the areas that we know will present challenges. These include:

- 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 develop a more coherent and joined up approach to 'market management' as an important area of focus for 2016/17 – 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
- ensuring we benefit in 2016/17 from our prolonged 'section 75' partnership agreement negotiations – whilst it took longer than planned to finalise in 2015/16, commitment between partners to the delivery of our BCF plan meant that it didn't hinder progress in implementing plans and we now have a strong basis for 2016/17.

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 that there are still significant opportunities to bring services closer together and maximise the benefits for people in Surrey.

There is a large body of evidence in support of integrating health and social care services for improved outcomes for patients. Alongside the national evidence and policy drivers, in Surrey, the Joint Strategic Needs Assessment (JSNA) provides the foundation for all strategic decision making. It presents a shared evidence base that is used by all partners when developing plans. Local health profiles have been created which present 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.

The JSNA and local health profiles tell us that Surrey has an ageing and growing population. In 2015 the population of Surrey was an estimated 1.17 million people, projected to rise to 1.37 million people by 2037 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 people living with dementia in Surrey is 24.4% from 2012 to 2020.

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; increases in permanent admissions to residential and nursing care homes, whilst there is a shortage of extra care housing available. The annexed local narratrives/actions plans demonstrate how risk stratification is used in each CCG area to plan care, target and tailor services.


Patients 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 faces significant financial challenges. Despite increased allocations for CCGs and a 2% council tax precept for Adult Social Care, increasing or new demands, and requirements around the use of the 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, CCG and provider operational plans (yet to be published: guidance is available online).

The Surrey Health and Wellbeing Strategy sets out a clear, shared vision for partners and a framework to guide our work around integration.

Health and Wellbeing Surrey

Our shared vision

***Through mutual trust, strong leadership and shared values we will improve the health and wellbeing of Surrey people***

Our shared values:

- ***respect and dignity***
- ***commitment to quality of care***
- ***compassion***
- ***improving lives***
- ***working together for people and carers***
- ***everyone counts***

The Surrey Better Care Fund plan 2016/17 maintains the same focus on older adults as our 2015/16 plan.

The Surrey Health and Wellbeing Strategy identifies 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*

To achieve our vision we have agreed 3 strategic aims for our Better Care Fund plan:

**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*

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.

The Surrey Better Care Fund plan 2016/17 has been developed in the context of the 3 emerging Sustainability and Transformation Plans (STPs) that cover Surrey – delivery of the vision and actions contained within this plan 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; and the finance and efficiency gap.

Surrey's Better Care Fund plan 2016/17 has been built on the foundations set in 2015/16 – many of the schemes that were established last year will continue into 2016/17. As mentioned earlier, we have learnt a great deal during year one of the Better Care Fund and as part of the review we conducted in January 2016, 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 action plans / narratives – these, together with the CCG Operating Plans, set out the actions that each area will take to deliver integrated health and care services. The transformation of services in each area to implement the vision of the Five Year Forward View and shift towards integrated health and social care services by 2020 can be summarised as follows:

East Surrey: *We will be developing our overarching model of care, in line with our STP development, as part of our community services procurement and the development of more formal joint commissioning arrangements in early 2016/17.*

Guildford & Waverley: *Our delivery objective in 2016/17 is to further develop an accountable integrated urgent care community that is responsive to patients and carers in crisis and delivers care in the most appropriate way.*

North East Hampshire & Farnham: *Integrated care is underpinned by our Primary and Acute Care System Vanguard – this accelerates 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, during 2016/17, our new model of care will support 7 day working across our 5 integrated locality areas and increased clinical partnerships between primary and secondary care.*

North West Surrey (incl. the Surrey element of Windsor, Ascot & Maidenhead): *In 2016/17, as we build towards our 2017 Model of Care, our aim is to embed our Integrated Care model across our system and across our practices to demonstrate a significant impact on avoidable admissions. Key elements include continuing to encourage the development of the primary care practice federation model and implementation of our three Locality Hubs.*

Surrey Downs: *Providers and commissioners have come together in Epsom to develop a long-term model of care that we will seek to implement over the next five years – it focusses on providing pro-active, preventative care to stop older people becoming unwell in the first place. When deterioration is unavoidable, the model aims 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).*

Surrey Heath: *Social care and community health services working across the system 7 days a week, coordinating services to keep people out of hospital and to return them home as quickly as possibly following an acute admission. During 2016/17 social care locality staff will be fully integrated into the Integrated Care teams and Single Point of Access within Surrey Heath.*

As a Surrey-wide system, these local approaches are supported by a range of enabler and cross-cutting projects and workstreams including digital transformation (including the emerging digital roadmaps); joint commissioning and market management; workforce development; and a review of all accommodation with care and support options against pathways, supply and demand to align with new operating models.

# governance, financial risk sharing & contingency

The **governance and accountability arrangements** in place to drive the delivery of integration across Surrey have matured through 2015/16 and are now well established.

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 Clinical Commissioning Group areas with membership made up of the relevant CCG, the County Council and other local stakeholders. It is at this local level where the development, management and oversight of delivery of local plans takes place, in addition to being 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.

At a Surrey-wide level, working on behalf of the Surrey Health and Wellbeing Board, the Surrey Health and Social Care Integration Board (formerly the Better Care Board) provides strategic oversight and leadership. Specific joint working groups / arrangements have been established to lead on key cross-cutting workstreams (such as data sharing/digital transformation and equipment and adaptations) and to coordinate and track delivery against the BCF metrics.

The Surrey Transformation Board continues to provide a regular forum for commissioners and providers across Surrey to engage and shape key aspects of work around integrated care. The emerging governance arrangements for the STPs across Surrey will further strengthen joint working and the emphasis on person centred, place-based transformation.

**Risk sharing** for BCF 2016/17 is based upon the principles agreed for BCF 2015/16 and is clearly set out in the 'section 75' agreements agreed between the County Council 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. Annex five is our agreed risk sharing statement.

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). Annexed to this plan is the overall Surrey BCF risk register covering strategic / shared risks – this has been developed building on the 2015/16 BCF risk register and based upon risks and potential issues identified in discussions at both a LJCG and Surrey-wide level.

In line with the 2016/17 BCF national conditions 7 and 8 and a local assessment of risk the following contingency allocations have been made:

- No specific local risk sharing arrangements or contingency has been made in relation to delayed transfers of care (principally due to relative high performance and confidence in achievability of the agreed target)
- Contingency amounts have been identified and agreed locally (at LJCG level) within the Surrey BCF in relation to the risk of non-achievement of non-elective admissions. These are set out in the BCF planning return template and are based upon an analysis of 2015/16 activity and local trends/forecasts.

**National condition 1: Plans to be jointly agreed**

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 April 2016.

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 national guidance.

In developing the local plans that this BCF plan is built upon, local providers have been engaged by each of the LJCGs and through the Surrey-wide Transformation Board (see National Condition 6 below). 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.

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.

**National condition 2: Maintain provision of social care services**

The BCF planning Return sets out clearly the amounts of funding allocated to:
- Maintain provision of social care services – this is made up of two elements:
  - £25M funding to towards a range of preventative services with system-wide benefits. This includes core services for reablement; hospital based teams; community equipment; some housing related support; voluntary sector grants; and carers.
  - £4.2m funding for adult social care staffing across areas such as supporting 8am-8pm working hospital based social care teams; additional capacity in reablement teams; and occupational therapy.
- Implementation of the new Care Act duties - £2.6m. This is a 1.8% increase on the allocation from 2015/16 in line with the increase in national allocations.
- Dedicated to carers specific support - £2.5m. This is a 1.8% increase on the allocation from 2015/16 in line with the increase in national allocations.

In agreeing the allocation of funds to adult social care discussions have been held in each LJCG area to review how the funds are used (the local 'definition') and the level of funding to secure stability of the local health and social care system.

**National condition 3: Delivery of 7-day services**

Our CCG Operating Plans for 2016/17 set out the overall approach to delivery of 7 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 7 days a week, coordinating services to keep people out of hospital and to return them home as quickly as possible following an acute admission. The annexed 'local action plans / narratives' provide a summary of the action being taken and services in place to meet this condition in each LJCG area.

**National condition 4: Better Data sharing**

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. The Surrey Information Governance Group (SIGG) has been formed with membership consisting of Information Governance Leads from each organisation.

The NHS Number is the established consistent identifier for health services. It is recorded in Adult Social Care (ASC) data, and individuals can be searched for, using the number. We anticipate full integration of our ASC system with the Personal Demographics Service, to enable real-time allocation of the NHS Number by March 2017. ASC aim to display the NHS number, alongside their local system generated number, on all correspondence, by March 2017.

Digital Roadmap activity is underway and confirms that, of those health and social care services who have submitted their current plans, they are in active pursuit of interoperable Application Programming Interfaces (APIs) and ensuring the necessary security and controls are either in place or being developed.

SIGG has developed the Surrey Information Sharing Agreement (ISA) for the provision of direct care – a framework that is being administered by the County Council and governed by the SIGG and the memberships' Caldicott Guardians and Senior Responsible Officers. The ISA and SIGG have been established to ensure we have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance. SIGG quarterly meetings include a review of the Surrey ISA to allow iterative improvements. The Surrey ISA is in beta development, and already hosting a number of projects. The aim is for 'full go live', subject to full consultation across partners, by September 2016.

Services have their own individual methods for ensuring that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review). The SIGG have been approached to develop a common consent to share model, to encourage consistent communication of all of the above, across Surrey. This is due to be completed by March 2017.

Our work has been informed by Healthwatch Surrey research carried out in 2015/16 – on the basis that the right safeguards are in place, there was strong support from respondents for sharing health and care records with health and care professionals involved in their care. The full report is published on the Healthwatch Surrey website.

The Surrey ISA, establishment of the SIGG and the commitment by services to lawfully and securely share data for the provision of care, means that new models and service redesigns can move forward at scale and pace. The ISA will act as a register of all of the data sharing projects we have underway across Surrey, allowing us to track and monitor activity, promoting transparency and shared learning.

For North East Hampshire and Farnham CCG, the Hampshire wide interface for IT is also important – the annexed local narrative provides detail of the plans and progress made.

Further detail will be made available through the following Digital Roadmaps relating to Surrey health and social care services: North West Surrey (with partners); Southampton, Hampshire, Isle of Wight and Portsmouth; Windsor, Ascot and Maidenhead (with partners); and Coastal West Sussex (with partners).

**National condition 5: Joint approach to assessments and care planning**

**National condition 6: Consequential impact on providers**

The annexed 'local action plans / narratives' set out the action taken, plans developed and decisions made for each LJCG area to meet the national conditions 5 and 6.

**National condition 7: Investment in NHS commissioned out-of-hospital services**

The BCF planning Return sets out clearly the amounts of funding invested in NHS commissioned out-of-hospital services and any agreed allocations for contingency.

The total invested in NHS out-of-hospital services across Surrey is £26.8m.

**National condition 8: Action plan to reduce delayed transfers of care**

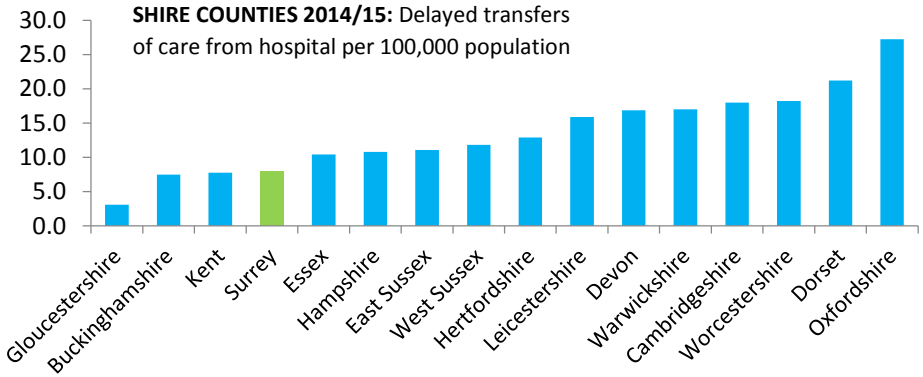
Surrey performs well in reducing delayed transfers of care compared to other areas and despite increasing demands we have achieved a level of stability over recent years through the action we have taken.

We have established a range of arrangements and services across Surrey that are helping us to minimise and prevent delays with significant coordination between health providers, community and social care as well as well our voluntary sector partners. We have robust and regular reporting mechanisms to enable us to closely track performance. This coordination and information gives us as a system clear oversight of the causes of delays and enables us to take the necessary action.

As part of the BCF planning process we have reviewed our local actions plans in line with best practice - this is reflected in the joint action plan annexed to this document. Examples of the actions we have in place are also included in the annexed local action plans / narratives and include:

- 7 day social care assessment services in acute hospital settings
- community health services 7 day working within both acute and community settings
- discharge to assess schemes
- programmes / work with voluntary sector partners

With the improvements made over the last year, and performance that has bucked the national trend, we have agreed a target to maintain performance at the 2015/16 level which is stretching given the increasing demand from an ageing population.



# annexes

| | |
|---|---|
| annex one | - Surrey BCF Planning Return |
| annex two | - Surrey BCF local action plans/narratives |
| annex three | - Surrey BCF risk register |
| annex four | - Delayed transfers of care action plan |
| annex five | - Risk share statement |