Notice of Meeting

Health, Integration and Commissioning Select Committee

Date & time
Friday, 8 March 2019 at 10.00 am

Place
Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN

Contact
Huma Younis
Room 122, County Hall
Tel 020 8213 2725

Chief Executive
Joanna Killian

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Huma Younis on 020 8213 2725.

Elected Members
Mrs Mary Angell, Dr Bill Chapman, Mr Nick Darby (Vice-Chairman), Mr Graham Ellwood, Dr Zully Grant-Duff (Chairman), Mr Graham Knight, Mrs Tina Mountain, Mr John O'Reilly, Mrs Fiona White and Mrs Clare Curran

Independent Representatives:
Borough Councillor Darryl Ratiram (Surrey Heath Borough Council), Borough Councillor Mrs Rachel Turner (Tadworth and Walton) and Borough Councillor David Wright (Tillingbourne)

TERMS OF REFERENCE

The Committee is responsible for the following areas:

- Statutory Health Scrutiny
- Health Integration and devolution
- Review and scrutiny of all health services commissioned or delivered within Surrey
- Public Health
- Review delivery of the Health and Wellbeing Strategy
- Health and Wellbeing Board
- Future local delivery model and strategic commissioning

AGENDA

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

To report any apologies for absence and substitutions

2 MINUTES OF THE PREVIOUS MEETING: 7 NOVEMBER 2018 (Pages 5 - 28)

To agree the minutes of the previous meeting as a true and accurate record of proceedings.

3 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter:

i. any disclosable pecuniary interests and / or;

ii. other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest;
- as well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner); and
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

4 QUESTIONS & PETITIONS

To receive any questions or petitions

Notes:

1. The deadline for Member's questions is 12.00pm four working days before the meeting *(Monday 4 March 2019).*
2. The deadline for public questions is seven days before the meeting *(Friday 1 March 2019).*
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 RESPONSE FROM THE CABINET TO ISSUES REFERRED BY THE SELECT COMMITTEE

There are no responses to report.

6 SOUTH EAST COAST AMBULANCE SERVICE UPDATE (Pages 29 - 44)

Purpose of the Report: This report updates the Committee on the South East Coast Ambulance Service, with special focus on the recent CQC report, Executive leadership development, performance reporting and associated strategic operational updates, alongside other local performance and development initiatives for Surrey.

7 DRAFT JOINT HEALTH AND WELLBEING STRATEGY FOR SURREY (Pages 45 - 88)

Purpose of the Report: This report provides the Select Committee with the opportunity to consider and comment on the draft Joint Health and Wellbeing Strategy for Surrey.

8 SUBSTANCE MISUSE SERVICE REPORT (Pages 89 - 114)

Purpose of the Report: In July 2018, Surrey County Council implemented changes to the commissioning of Substance Misuse treatment following a review of these services. For the Select Committee to consider the progress made in the changes to the adult substance misuse treatment system.

9 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME (Pages 115 - 120)

Purpose of the Report: The Select Committee is asked to review and approve the Recommendations Tracker and Forward Work Programme providing comment as required.

10 HEALTH, INTEGRATION AND COMMISSIONING SELECT COMMITTEE BULLETIN (Pages 121 - 124)

Purpose of the Report: To update Members of the Committee on key issues relating to the delivery of healthcare services in Surrey and detailing work underway to scrutinise these.

11 MAPPING THE PATIENT'S JOURNEY THROUGH ADULT MENTAL HEALTH SERVICES IN SURREY- TASK AND FINISH GROUP SCOPING DOCUMENT (Pages 125 - 134)

Purpose of report: For the Select Committee to review and comment on the attached task and finish group scoping document.

12 DATE OF THE NEXT MEETING

The next meeting of the Select Committee will be held at 10:00 on 13 June 2019 in the Ashcombe Suite at County Hall.

Joanna Killian
Chief Executive
Published: Thursday 28 February, 2019

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

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Thank you for your co-operation

MINUTES of the meeting of the **HEALTH, INTEGRATION AND COMMISSIONING SELECT COMMITTEE** held at 10.00 am on 7 November 2018 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Friday, 8 March 2019.

(* = in attendance)

Elected Members:

	Mrs Mary Angell
*	Mr Bill Chapman
*	Mr Nick Darby
*	Mr Graham Ellwood
*	Dr Zully Grant-Duff (Chairman)
	Mr Graham Knight
*	Mrs Tina Mountain
*	Mr John O'Reilly
	Mr Wyatt Ramsdale (Vice-Chairman)
*	Mrs Fiona White
*	Dr Andrew Povey
*	Mr Keith Witham

Co-opted Members:

*	Borough Councillor Darryl Ratiram, Surrey Heath Borough Council
*	Borough Councillor Mrs Rachel Turner, Tadworth and Walton
*	Borough Councillor David Wright, Tillingbourne

Substitute Members:

Dr Andrew Povey
Mr Keith Witham

In attendance

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Helen Atkinson, Executive Director of Public Health, Surrey County Council

Andrew Baird, Democratic Services Officer, Surrey County Council

Tumi Banda, Associate Director for Working Age Adult Inpatient Services, Surrey and Borders Partnership NHS, Foundation Trust

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Nick Jones, PwC

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Tim Oliver, Cabinet Lead Member for People

Matthew Parris, Deputy CEO, Healthwatch Surrey

Lorna Payne, Chief Operating Officer, Surrey and Borders Partnership NHS Foundation Trust

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

Justin Wilson, Medical Director, Surrey and Borders Partnership NHS Foundation Trust

10 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Mrs Mary Angell and Mr Wyatt Ramsdale.

Mr Keith Witham acted as a substitute for Mary Angell.

Dr Andrew Povey acted as a substitute for Wyatt Ramsdale.

11 MINUTES OF THE PREVIOUS MEETING: 4 JULY 2018 [Item 2]

A revised set of minutes were tabled at the meeting. The minutes were approved as a true record of the meeting.

12 DECLARATIONS OF INTEREST [Item 3]

There were none

13 QUESTIONS & PETITIONS [Item 4]

Three public questions were submitted individually to the Committee by Liz Sawyer, Stephen Fash and Sheila Boon. Responses to each of these questions were tabled at the meeting and are attached as Annex 1 to these minutes.

14 RESPONSE FROM THE CABINET TO ISSUES REFERRED BY THE SELECT COMMITTEE [Item 5]

There were none.

15 TEN YEAR STRATEGIC PLAN FOR SURREY [Item 7]

It was agreed that, due to the availability of officers, this item would be considered before Item 6.

Declarations of interests:

There were none

Witnesses:

Helen Atkinson, Executive Director of Public Health, Surrey County Council

Nick Jones, PwC

Tim Oliver, Cabinet Lead Member for People

Matthew Parris, Deputy CEO, Healthwatch Surrey

Key points raised during the discussion

Mr Graham Ellwood entered the meeting at 10.11am

1. The Committee received an introduction to the report from witnesses who informed Members of the reasons why a Ten Year Strategic Plan for Surrey was being developed and the steps that were being taken in order to build a consensus around shared priorities for the health and care system in the County. These priorities would be informed by extensive engagement with stakeholders and the public as well as from the findings of the intelligence-gathering programme being conducted by PwC.

2. Clarity was sought from Members of the Committee on whether the Strategic Plan would focus exclusively on improving the health and wellbeing of Surrey residents. Members heard that the PwC had spoken to a range of partners during the intelligence-gathering exercise which had included seeking the views of public sector partners beyond health and social care. The Strategic Plan would form part of the new 'Vision for Surrey in 2030' which had been developed by Surrey County Council as part of a single plan to align priorities for all public sector investment in Surrey.

3. Members requested further information on how the Strategic Plan would interact with the three Sustainability and Transformation Partnership (STPs) footprints that are wholly or partly in Surrey. The Committee was informed that the Plan would sit above STPs and would be owned by the Health and Wellbeing Board in accordance with its statutory requirement to produce a Joint Health and Wellbeing Strategy. The membership of the Health and Wellbeing Board was being reviewed to incorporate a much wider range of partners whose voices would taken into account on delivery against agreed outcomes.

4. Discussions turned to the length of time that it would take for efforts to improve population health in Surrey to be realised with some Members suggesting that it could take a generation or more to mitigate demand arising from poor lifestyle choices. The Committee heard that it was vital to focus on prevention and early intervention to ensure that the health and social care system can manage demand within the budget envelope available and to reduce health inequalities in the County. Witnesses highlighted that evidence collated by PwC and contained within Surrey's Joint Strategic Needs Assessment had shown that prevention could have a significant impact in the medium term.

5. The Committee highlighted the importance of engaging with the voluntary, community and faith sector (VCFS) as well as with local businesses regarding the development of priorities for the Strategic Plan. Members were advised that PwC had engaged with VCFS organisations seeking their initial view on the plan but that further engagement work would be conducted with them on shaping priorities.

6. The Committee enquired as to whether there was the potential for the Strategic Plan to conflict with the Council's 'Vision for Surrey in 2030'. Members heard that these were part a single strategy for the delivery of public and voluntary sector services in Surrey. There was close alignment between the Strategic Plan being considered by the Select Committee and the five strategies that had been agreed by Cabinet at its meeting on 30 October 2018.

7. Clarity was sought on what role residents and patients had played in identifying priorities for the Strategic Plan. The Committee was informed that it was important to have a framework for engagement to support an informed conversation with the public regarding priorities. A commitment was made to adhere to Healthwatch England's Five Principles for Good Public Engagement when developing Surrey's Ten Year Strategic Plan.

Actions/ further information to be provided

None

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. notes the strategic planning work that has commenced;
ii. provides feedback on the strategic planning work and on the emerging finds presented at the meeting, adding insight from the work the Committee has undertaken to help shape the approach; and
iii. convenes a Task Group to conduct ongoing scrutiny of the 10 Year Strategic Plan for health and social care as it develops and proposes the following areas as an overarching remit for the Task Group:
    a. health inequalities;
    b. outcomes framework; and
    c. how implementation of the proposed plan will deliver against agreed outcomes

16 HEALTH INTEGRATION AND COMMISSIONING SELECT COMMITTEE BULLETIN [Item 6]

Declarations of Interests:

None

Witnesses:

None

Key points raised during the discussion:

1. The item was introduced by the Chairman of the Select Committee who advised that the bulletin was a means of keeping Members updated regarding the work she had undertaken between select committee meetings.

2. A Member enquired about the work of the Improving Healthcare Together 2020 – 2030 Sub-Committee and asked how Members of this Sub-Committee were mitigating the bias of the Chief Executive of Epsom and St Helier University Hospitals Trust. The Chairman advised that the Improving Healthcare Together 2020 – 2030 Programme was the responsibility of commissioners and the Sub-Committee had engaged only with the commissioners which meant that there had been no contact with the Chief Executive of the Trust.

Actions/ further information to be provided:

None

RESOLVED:

None

17 WORKING WITH PATIENTS TO IMPROVE MENTAL HEALTH SERVICES: AN UPDATE ON RECENT WORK BY HEALTHWATCH SURREY [Item 8]

Declarations of Interests:

A non-pecuniary interest was declared by Bill Chapman who advised that he was a Governor of Surrey and Borders Partnership NHS Foundation Trust.

Witnesses:

Tumi Banda, Associate Director for Working Age Adult Inpatient Services, Surrey and Borders Partnership NHS, Foundation Trust

Matthew Parris, Deputy CEO, Healthwatch Surrey

Lorna Payne, Chief Operating Officer, Surrey and Borders Partnership NHS Foundation Trust

Justin Wilson, Medical Director, Surrey and Borders Partnership NHS Foundation Trust

Key points raised during the discussion:

1. The Committee received an introduction on the role of Healthwatch Surrey (HWSy) within the health and social care system in the County. Members heard that Healthwatch used various methods to gain insights into patient experiences around the delivery of specific

services making recommendations to commissioners and providers in response to these.

2. Further information was also provided on the Enter and View visit to the Abraham Cowley Unit (ACU), a mental health inpatient unit operated by Surrey and Borders Partnership NHS Foundation Trust. The Committee heard the reasons behind HWSy's decision to invoke its statutory power to undertake an Enter and View visit at the unit and were informed of the methodology used and engagement conducted by HWSy to collect evidence during their visits. SABP had been very responsive in seeking to address the problems identified by HWSy officers during their visit but that there appeared to be some long-term challenges that it was necessary for the Trust to address regarding its inpatient provision. The Committee was informed that staffing levels and the environment were the two key challenges at the ACU.

3. Representatives from SABP were given the opportunity to respond to the findings of the Enter and View Report. It was acknowledged that the capacity to recruit and retain good quality nursing staff as well as the environment created significant challenges for the provision of inpatient care at the ACU. Members heard that plans were being developed to improve the quality of the environment in working age adult wards through rebuilding and refurbishment alongside a building programme to improve inpatient mental health service units across the county. The Committee was advised that SABP had commissioned an independent review to make recommendations on how the Trust could improve patient experiences at the ACU.

4. Discussions turned to the use of dormitories to house patients at the ACU and the Committee was advised that many patients had reported that sleeping in dormitories had impacted negatively on them. Members of the Committee requested that SABP commit to a clear timescale on when dormitories would be replaced with single occupancy rooms. Representatives from SABP acknowledged that dormitories were not optimum for accommodating mental health inpatients but stressed that the sums associated with refurbishing the ACU were significant. The Trust was progressing its plans to have three mental health inpatient hospitals in Surrey but already had funding in place to refurbish the ACU irrespective of whether they received financial backing for the three hospital solution. Members were advised that, when taking demand into account, SABP's inpatient services were currently over 100% occupancy and that a plan was needed to build some capacity within the Trust's existing provision to allow the refurbishment work to commence.

5. Discussions turned to the significant number of negative experiences recorded by HWSy from among those who had used mental health inpatient services in Surrey. Representatives from SABP informed the

Committee that the majority of those who used mental health inpatient services were there involuntarily having been sectioned under the Mental Health Act. As such, their experiences would necessarily be less positive when compared to those who use other types of healthcare services such as Primary Care. Representatives from SABP confirmed that the Trust also recorded patient experience and used this feedback to inform and improve their services which had led to improvements in mental health inpatient provision over recent years.

6. Members discussed funding for mental health services in Surrey highlighting that less was spent per head in the County than in many other local authority areas. The Committee highlighted the need to lobby Government to ensure that Surrey got a fair deal from allocations that had been made available by the Department of Health and Social Care in order to establish parity of esteem with physical health. It was agreed that the Committee should write to the Secretary of State for Health and Social Care regarding the availability of funding for mental health services in Surrey.

7. Conversations took place regarding specific actions that the Committee could hold SABP accountable against for improving the experience of those who used inpatient mental health services in Surrey. Members heard that the Trust had produced an Improvement Plan in response to the Care Quality Commission report on the ACU which the Committee could use to hold SABP account for its performance. It was agreed that the Improvement Plan would be circulated to the Committee for this purpose.

Actions/further information to be provided:

1. SABP Improvement Plan in response to CQC inspection report on the Abraham Cowley Unit to be circulated to the Committee.

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. recognises that mental health provision is comprised of various service areas including prevention, resilience, CAMHS, community and inpatient services. The Committee restated its commitment to conduct ongoing scrutiny of mental health provision in Surrey, in particular through direct engagement with service users, commissioners and providers, for review at its March meeting;

ii. restates its commitment to conduct ongoing scrutiny of mental health provision in Surrey, in particular through direct engagement with service users, commissioners and providers, for review at its March meeting; and

iii. considers the key points raised and recommendations made at the Adult and Health Select Committee meeting of 9 November 2017 when planning further scrutiny of inpatient mental health services, in particular reviewing how performance is assessed from the patients' perspective.

18 SEXUAL HEALTH AND HIV SERVICES CONTRACT [Item 9]

Declarations of Interests:

None

Witnesses:

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Matthew Parris, Deputy CEO, Healthwatch Surrey

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

Key points raised during the discussion:

1. The Committee acknowledged that significant improvements had been made in the provision of Sexual Health and HIV Services in the intervening period since the Service had last been scrutinised. Concern was, however, expressed about access into the service for those who feel less comfortable booking appointments or requesting testing kits online. Members were advised that online was one of a number of access points into the Service for residents and that Central and North West London NHS Foundation Trust (CNWL) had adapted services to ensure accessibility.

2. Members sought clarity on progress that had been made to resolve some of the initial issues experienced by the service when the contract commenced with CNWL such as disabled access to clinics, increase in GP referrals and problems with the telephone system. The Committee heard that steps had been taken to address these issues in consultation with patients and stakeholders. This had included work with Disabled Go and Surrey Coalition of Disabled People who had made recommendations regarding how to improve the accessibility of clinics to those with disabilities.

3. Discussions turned to the availability of services through the hub, spoke and outreach model implemented by CNWL. All of the spokes were fully operational and consultants had all been trained to treat

both GUM and sexual health conditions which meant that there was greater flexibility within the Service.

4. The Committee asked whether Sexual Health and HIV Services in Surrey were better than they had been before CNWL took over the contract in April 2017. Members were advised that the new service model offered a variety of access points into the service, in particular the use of online services to be able to cover the geography of Surrey. This meant that consultant time could be targeted more effectively towards those with the most acute conditions which was vital given the reduced financial envelope available to commission sexual health services. Witnesses also emphasised the challenges inherent in bringing three separate services together into a single Sexual Health and HIV Service for Surrey.

5. Members heard that HWSy had held an event at Buryfields Clinic in Guildford to find out more about the experiences of patients and that, among a very small sample, the majority who spoke to HWSy indicated that they were very happy with the services they had received. Some patients had, however, expressed concern about reductions in the number of Sexual Health Advisors. Representatives from CNWL stated that patients in HIV treatment who have an undetectable viral load could not pass on the virus and the service had very good partner notification rates. CNWL had retained one SHA but it was felt that resources previously allocated to SHAs would be better targeted elsewhere.

Actions/ further information to be provided:

None

RESOLVED:

That the Health, Integration and Commissioning Select Committee notes the performance of the sexual health and HIV treatment and care service contracts.

19 RESPONSE FROM NHS ENGLAND SPECIALISED COMMISSIONING AND SURREY COUNTY COUNCIL TO RECOMMENDATIONS MADE BY THE HEALTH INTEGRATION AND COMMISSIONING SELECT COMMITTEE [Item 10]

Declarations of Interests:

None

Witnesses:

Lisa Andrews, Senior Public Health Lead, Surrey County Council

Dr Simon Edwards, Clinical Director, Central and North West London NHS Foundation Trust

Ruth Hutchinson, Deputy Director of Public Health, Surrey County Council

Fiona Mackison, Service Specialist, NHS England Specialised Commissioning

Matthew Parris, Deputy CEO, Healthwatch Surrey

Stephen Tucker, Deputy Service Director, Sexual Health and HIV, Central and North West London NHS Foundation Trust

Key points raised during the discussion:

1. The Committee commended CNWL, NHSE Specialised Commissioning and Surrey County Council for their work in implementing recommendations made by the Health Integration and Commissioning Select Committee.

2. Members were informed that the NHSE Specialised Commissioning South had put all of its staff through patient engagement training in response to the work of the Sexual Health Services Task Group and the recommendations made by the Select Committee.

Actions/ further information to be provided:

None

RESOLVED:

That the Health Integration and Commissioning Select Committee notes the progress made by Central and North West London NHS Foundation Trust, NHS England Specialised Commissioning and Surrey County Council within the implementation of its recommendations.

20 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of Interest:

None

Witnesses:

None

Key points raised during the discussions:

None

Actions/ further information to be provided:

None

RESOLVED:

That the Health Integration and Commissioning Select Committee:

i. reviews items that it is due to consider at future meetings; and

ii. reviews progress against actions and recommendations as captured within the Committee's Recommendations Tracker.

21 DATE OF THE NEXT MEETING [Item 12]

The Committee noted that its next meeting would be held on 8 March 2019.

Meeting ended at: 12.53 pm

Chairman

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ITEM 4

Questions to the Health, Integration and Commissioning Select Committee – 7 November 2018

1. Question submitted by Liz Sawyer

What metrics do the committee use to assess whether the services commissioned by Surrey County Council are meeting the Council's sexual health priorities and to assess whether the sexual health of Surrey residents is improving?

Response

The Committee has a scrutiny function and in this regard exercises collective judgement when requesting and reviewing information and data from health commissioners and providers.

The Committee has asked requested a response from Surrey County Council regarding the metrics that they use to assess performance in delivering against sexual health priorities and has received the following response:

'The performance and quality of the sexual health service are monitored through three methods:

- the Public Health Outcomes Framework indicators (PHOF) – full list below
- quarterly monitoring reports, that include key performance indicators (KPIs) presented at contract meetings (full list below), and
- patient and stakeholder feedback. Patient feedback is gathered in a number of ways including via anonymous customer feedback cards.

An update on performance against the PHOF and contracted activity for clinic appointments and online testing can been found in Performance and Quality section of the HICSC report. The report is presented at item 9 of the agenda

Public Health Outcomes Framework indicators (PHOF)

Indicator	Explanation
Syphilis diagnostic rate / 100,000	All syphilis diagnoses among people accessing specialist and non-specialist sexual health services* in England who are also residents in England, expressed as a rate per 100,000 population.
Gonorrhoea diagnostic rate / 100,000	All gonorrhoea diagnoses among people accessing sexual health services* in England who are also residents in England, expressed as a rate per 100,000 population.
Chlamydia detection rate / 100,000 aged 15-24	All chlamydia diagnoses in 15 to 24 year olds attending specialist and non-specialist sexual health

Indicator	Explanation
	services (SHSs)*, who are residents in England, expressed as a rate per 100,000 population
Chlamydia proportion aged 15-24 screened	All chlamydia tests (asymptomatic screens and symptomatic tests) undertaken in 15 to 24 year olds attending specialist and non-specialist SHSs* who are residents in England.
New STI diagnoses (exc chlamydia aged <25) / 100,000	STI diagnoses (excluding chlamydia in under 25 year olds) among people accessing specialist and non-specialist sexual health services* in England. Data are expressed as a rate per 100,000 population aged 15 to 64 years.
HIV testing coverage, total (%)	Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis.
HIV late diagnosis (%)	Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis.
New HIV diagnosis rate / 100,000 aged 15+	All new HIV diagnoses among adults (aged 15 years or more) in the UK, expressed as a rate per 100,000 population
HIV diagnosed prevalence rate / 1,000 aged 15-59	People aged 15 to 59 years seen at HIV services in the UK, expressed as a rate per 1,000 population.
Population vaccination coverage – HPV vaccination coverage for one dose	All girls aged 12-13 years who have received the first (priming) dose of the HPV vaccine within each reporting area (local authority - LA) as a percentage of all girls aged 12-13 years within each area
Under 25s repeat abortions (%)	Percentage of abortions in women aged under 25 years that involve a women who has had a previous abortion in any year.
Abortions under 10 weeks (%)	Percentage of all NHS-funded abortions performed under 10 weeks gestation
Total prescribed LARC excluding injections rate / 1,000	Crude rate of long acting reversible contraception (LARC) excluding injections prescribed by GP and Sexual and Reproductive Health Services per 1,000 resident female population aged 15-44 years
Under 18s conception rate / 1,000	Conceptions in women aged under 18 per 1,000 females aged 15-17. Numerator is the number of pregnancies that occur in women aged under 18 and result in either one or more live or still births or a legal abortion

Indicator	Explanation
Under 18s conceptions leading to abortion (%)	The percentage of conceptions to those aged under 18 years that led to an abortion
Sexual offences rate / 1,000	Rate of sexual offences based on police recorded crime data per 1,000 population

Key Performance Indicators

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
Clinical Management				
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment undertaken[1]	100%	BASHH Standard 1[2]	Clinical Audit	Remedial Action Plan
Monitor percentage of first time service user (of clinical based services) offered and accepting an HIV test		For local determination (To support Public Health Outcome Framework 3.4)	GUMCAD	Remedial Action Plan
Percentage of routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within seven working days of a specimen being taken	100%	BASHH Standard 4	Clinical Audit	Remedial Action Plan
Ratio of contacts per gonorrhoea index case, such that the attendance of these contacts at a Level 1, 2 or 3 service was documented as reported by the index case, or	0.6 contacts, and documented within four weeks of the date of the first PN discussion[3] [4]	BASHH Statement on Partner Notification for Sexually	Clinical Audit	Remedial Action Plan

[1] Does not include individuals accessing self-managed care (Section 3.2.1)

[2] BASHH (British Association Sexual Health & HIV) and MEDFASH (2010). *Standards for the Management of Sexually Transmitted Infections (*http://www.medfash.org.uk/publications)

[3] Corrigendum *BASHH Statement on Partner Notification for Sexually Transmissible Infections,* May 2013 (http://www.bashh.org/documents/Corrigendum%20BASHH%20Statement%20on%20Partner%20Notification%20for%20Sexually%20Transmissible%20Infections.pdf)

[4] Current standards recommend 0.4 and 0.6 contacts per index case dependent upon area of service delivery. However, Commissioners may consider aspirational targets of 0.6 and 0.8 contacts per index case in future, as evidenced by *Turner K. et al*, 2010 (http://www.bmj.com/content/342/bmj.c7250)

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
by a HCW, within four weeks of the date of the first PN discussion (within 12 weeks for HIV)		Transmissible Infections[25]		
Ratio of contacts of chlamydia index cases whose attendance at a Level 1, 2 or 3 service was documented as reported by the index case, or by a HCW, within four weeks of the date of the first PN discussion	At least 0.6 contacts per index case for all clinics (in and outside London), and documented within four weeks of the date of the first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections NCSP Standard 4	Clinical Audit	Remedial Action Plan
The ratio of all contacts of chlamydia index case whose attendance at a Level 1, 2, or 3 sexual health service was documented as verified by a HCW, within four weeks of first PN discussion	At least 0.4 contacts per index case for all clinics (in and outside London) and documented within four weeks of date of first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections NCSP Standard 4	Clinical Audit	Remedial Action Plan
Documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk	90%	BHIVA Standard 7[5]	Clinical Audit	Remedial Action Plan
Documented PN outcomes or a progress update at 12 weeks after the start of the process	90%	BHIVA Standard 7	Clinical Audit	Remedial Action Plan
Monitor period of time from consultation to receipt of results by service user		BASHH Standard 5	Clinical Audit	Remedial Action Plan
Percentage of women having access to and availability of the full range of contraceptive	100%	FSRH Standard 2[6]	Clinical Audit	Remedial Action Plan

[5] British HIV Association (2013). *Standards of Care for People Living with HIV* http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf

[6] Faculty of Sexual & Reproductive Healthcare (2013). *Service Standards for Sexual and Reproductive Healthcare* (http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf

Quality Outcomes Indicators	Threshold	Technical Guidance Reference (if applicable)	Method and Frequency of Measurement	Consequence of Breach
method (including choice within products)				
Monitor percentage of LARCs prescribed as a proportion of all contraceptives by age			Bi-annually	Remedial Action Plan
Percentage of women who have access to urgent contraceptive advice and services (including emergency contraception) within 48 hours of contacting the service			Bi-annually	Remedial Action Plan
Percentage of women including vulnerable groups (for example teenage mothers and looked after children) who have access to LARC method of choice within 15 working days of contacting service[32]			Bi-annually	Remedial Action Plan

Improving Productivity				
Percentage of staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant update requirements	100%	BASHH Standard 2	For local determination	Remedial Action Plan
Percentage of nurses dual trained to deliver contraceptive (including LARC methods) and GUM services		For local determination	For local determination	Remedial Action Plan
Training for wider sexual health workforce	Training needs analysis to be completed and action plan developed in collaboration with commissioners		Annually	
GP and pharmacy engagement	Attendance at CPPE and GP development events		Annually	

Establish a county wide sexual health network with a health improvement component to include commissioners, clinicians, key health care professionals and the wider partners	Evidence of clinical network including TOR, meeting agendas and action notes		Annually	
Surrey Safeguarding board attendance	Contribute to the priorities of both safeguarding boards in Surrey and attend sub-groups where appropriate		Annually	
Under 25s Services				
Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	Local tolerance of 1900/100,000	Public Health Outcome Framework measure (3.2)	CTAD Data	Remedial Action Plan
Percentage of all under 25 year olds screened for chlamydia	At least 75%of new attendances[7]	Contributes towards Public Health Outcome Framework measure (3.2)	For local determination (Drawing on CTAD where appropriate)	Remedial Action Plan
Percentage of all results notified to the young person within 10 working days (from test date)	At least 90%	NCSP Standard 4	For local determination	Remedial Action Plan
Percentage of positive patients who received treatment within six weeks of test dates	At least 95%	NCSP Standard 4	For local determination	Remedial Action Plan
Number of new registrations, young people repeat visiting and total repeat visits to c-card outlets by age/gender			Quarterly	Remedial Action Plan
Service User Experience across all services provided				
Maintain/achieve *You're Welcome* accreditation	100%	National Expectation	Within first year of contract and then every three years subsequently	Remedial Action Plan
Evidence of at least one user experience survey annually	100%	For local determination	Annually	Remedial Action Plan

[7] It is suggested that delivery of this threshold would be supported by offering chlamydia screening to 100% attendees on an opt out basis - Local information can be used to inform proportion of all attendances that should be screened for chlamydia based on first/follow up attendance ratio.

Percentage of service user feedback on surveys that rates satisfaction as good or excellent	70%	For local determination	Annually	Remedial Action Plan
Quality Outcomes Indicators	**Threshold**	**Technical Guidance Reference (if applicable)**	**Method and frequency of Measurement**	**Consequence of Breach**
Evidence of improvements made to service as a result of user feedback	Demonstrable evidence of improvements and changes made to service delivery in response to feedback	BASHH Standard 9	For local determination	Remedial Action Plan
Number of service users making formal complaints about the service (verbal or written)	Provider to notify Commissioner in accordance with *Incidents Requiring Reporting Procedure Section* - Appendix G	BASHH Standard 9	For local determination	Remedial Action Performance
Reducing Inequalities				
An Equality Impact Assessment (EIA) is undertaken and outcomes utilised to inform forward year planning	Completion of EIA	Locally Determined	Bi-annually	Remedial Action Plan
Provider to demonstrate that all functions and policies are equality impact assessed	Agreed programme to achieve compliance	Locally Determined	For local determination	Remedial Action Plan
Number of individual face to face contacts, non face to face contacts and sessions made by outreach services conducted in areas of high deprivation or aimed at vulnerable groups (MSM, Black African, Sex Workers and Young People including young parents and Looked After Children)	For local determination	Locally Determined	For local determination	Remedial Action Plan
Number of individual face to face contacts, non face to face contacts and sessions made by outreach services (to include clinic/ drop-in sessions)	For local determination	Locally Determined	For local determination	Remedial Action Plan

conducted in Further Education and University settings				
Provider to make available to clients, where appropriate, Chem Sex Packs (which includes, condoms, lube, information where to get support, some packs include syringes, spoons, gloves etc)	For local determination	Locally Determined	For local determination	Remedial Action Plan
Provider to provide basic brief advice with regards to safe sex whilst under the influence and other related topics.	For local determination	Locally Determined	For local determination	Remedial Action Plan
The provider is able to report by geography as specified by the commissioner to help understand how the services are tackling inequalities/working within areas of highest need	For local determination	Locally Determined	For local determination	Remedial Action Plan
The provider is able to report on the number of looked after children accessing the service and those with special educational need or disability	For local determination	Locally Determined	For local determination	Remedial Action Plan
Quality Outcomes Indicators	**Threshold**	**Technical Guidance Reference (if applicable)**	**Method and frequency of Measurement**	**Consequence of Breach**
Access				
Percentage of clients accessing service to be seen within 48 hours of contacting the service	85%	Locally Determined	For local determination	Remedial Action Plan
Percentage of people offered an appointment, or walk-in, within 48 hours of contacting a provider	98%	BASHH Standard 1	For local determination	Remedial Action Plan
Percentage of users experiencing waiting times in clinics of > 2 hours	For local determination	For local determination	For local determination	Remedial Action Plan
Percentage of clients waiting longer than *(to be agreed locally)* from booking to appointment	For local determination	Locally Determined	For local determination	Remedial Action Plan

Increase in the number of men accessing services	For local determination	Locally Determined	For local determination	Remedial Action Plan

Care pathways with other organisations to include partner notification and/or linked services (e.g. alcohol, mental health etc.) are clearly defined	Pathways established	BASHH Standard 7	For local determination	Remedial Action Plan
Fast track referral pathway established for professionals working with vulnerable young people i.e. young parents, those at risk of CSE, Looked After Children	Pathways established		For local determination	Remedial Action Plan
Percentage of specialist SRH referrals from general practice seen within 18 weeks of referral	For local determination	Locally Determined	For local determination	Remedial Action Plan
Percentage of psychosexual clients seen within 18 weeks of referral[8]	For local determination	Locally Determined	For local determination	Remedial Action Plan

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
7 November 2018

[8] This indicator may be omitted if the provision of psychosexual services forms part of a separate agreement

2. Question submitted by Stephen Fash

In view of the serious shortcomings identified in the commissioning process by the Sexual Health Services Task Group (Final Report received by the HIC Select Committee on 4 July 2018) – particularly the lack of effective engagement and communication with service users, GPs and other stakeholders and the failure to explore why all but one of the 22 prospective bidders chose not to submit a tender leading to the contract being awarded, uncontested, to a single bidder – will Surrey County Council, as the lead commissioner for the integrated Sexual Health & HIV Service for Surrey confirm that it will not extend the existing contract with Central & North West London NHS Foundation Trust for a further two years, as it is understood that the said contract allows or, if it is so minded, will not do so without undertaking full consultation with service users, GPs and stakeholders and will take full account of the views received in public session before making any such decision?

Response

The Committee has asked Surrey County Council to respond to your question and has received the following response:

'Surrey County Council has a process for the agreement of contract extensions. Any recommendation to extend a contract would take into account contract quality and performance (which for this contract includes engagement with residents and stakeholders) and value for money. This contract is jointly commissioned and therefore SCC and NHSE would discuss any extension to the contract and jointly agree any decision.'

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
7 November 2018

3. Question Submitted by Sheila Boon

Although CNWL were awarded the Surrey contract with effect from April 2017, it has only been meeting its full contract commitment since the closure of the Blanche Heriot Unit in October 2017 – how does the level of patient activity at the services operated by CNWL over the past year compare with the equivalent period in 2015/16 and what are the financial implications of work displaced to GPs or to other service providers?

Response

The Committee has asked Surrey County Council to respond to your question and has received the following response:

'CNWL are providing services with a new model of care. The service model commissioned has a greater focus on prevention and innovation meaning a shift from the traditional service model of face-to-face consultations to a service model where online booking, online triage and self-sampling (where service users are sent testing kits in the post and return a sample to the provider for testing) become more prominent. As the contract requirements are different, patient activity is therefore of a very different nature from the previous contracts held in 2015/16.

An update on performance against contracted activity for clinic appointments and online testing can been found in Performance and Quality section of the HICSC report. The report is presented at item 9 of the agenda.

As well as the CNWL contract, public health also commission some sexual health services from GPs and pharmacies. Over the past year, there has been an increase in long acting reversible contraception (LARC) spend in general practice. The sexual health commissioner is working with GPs, the LMC (Local Medical Committee) and the sexual health service on a review of LARC across the county with a particular focus on complex procedures.'

Dr Zully Grant-Duff
Chairman – Health Integration and Commissioning Select Committee
7 November 2018

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South East Coast Ambulance Service NHS Foundation Trust

Health, Integration and Commissioning Select Committee

8 March 2019

South East Coast Ambulance Service Update

Purpose of report:
This report updates the committee on the South East Coast Ambulance Service, with special focus on the recent CQC report, Executive leadership development, performance reporting and associated strategic operational updates, alongside other local performance and development initiatives for Surrey.

Introduction

Operational Overview of SECAmb

1. On 29 September 2017, the CQC published their findings following their inspection of the South East Coast Ambulance Service (SECAmb) which saw the Trust placed into special measures and an overall rating of 'inadequate' for the 999 service and an overall 'good' for the 111 service. The Trust was recognised as good for caring throughout.

2. Following this rating, SECAmb implemented a delivery plan with a clear focus on the key areas for improvement as indicated by the CQC. Since then SECAmb has been on an improvement trajectory, with the Trusts rating moving from 'inadequate' to 'requires improvement' in the subsequent report published 8th November 2018. A programme of continuous improvement is in place for the 1 Must Do item and the list of 10 items in the Should Do list of which 6 apply to Emergency and Urgent Care, 3 to the Emergency Operations Centre and 1 overall to the area of Resilience.

3. Following the NHS England commissioned review of urgent and emergency care in 2013 and the Sheffield University study into ambulance responses in 2015, the subsequent Ambulance Response Programme[1] (ARP), went live at SECAmb on 22nd November 2017.

4. Since ARP implementation, SECAmb has performed close to the national average for Category 1, better than average for Category 2 (although our improved management of patients that wait in lower categories has added to our overall response time recently). Category 3 and Category 4 responses remain challenging **(Annex 2 Table 2a)** and improvements are expected across the entire region in all categories based on the results of our jointly commissioned Demand and Capacity Review. This review set out the resource requirements, the cost of resource and hence income requirements for the Trust to deliver ARP standards.

[1] https://www.england.nhs.uk/urgent-emergency-care/arp/

5. The conclusion of the Demand and Capacity Review was a commissioner agreed investment in the recommended 'Targeted Dispatch Model'. The cost of meeting ARP standards is estimated at between c. £203m to £208m for 2019-20 and c. £215m to £219m for 2020-21 (£40m investment per annum cf 2016/17).The delivery of this model is through the Service Transformation and Delivery (STAD) Programme of staff recruitment and fleet procurement to March 2021.

Executive Leadership Development

6. SECAmb has continued to recruit to its Executive Team and Board with the following appointments:-

   - Steve Emerton: Executive Director of Strategy and Business Development on 2nd January 2018.
   - Ed Griffin: Executive Director for HR on 7th March 2018. Ed will be taking up a new role in the spring of 2019 and the process of recruitment has started to find his successor.
   - Bethan Haskins: Executive Director of Nursing and Quality on 1 April 2018.
   - Dr Fionna Moore: Executive Medical Director (substantive) following an interim period of the past 14 months.
   - David Astley: Chairperson during September 2018, following the departure of the Trusts Chairperson, Richard Foster. We also welcomed our new Non-Executive Director Michael Whitehouse.

7. In November 2018, the Trust announced that Chief Executive, Daren Mochrie, would be leaving SECAmb to take up a new role as Chief Executive of the North West Ambulance Service from 1 April 2019. The process to recruit Daren's successor is underway, led by the Chair David Astley. The first round of interviews have taken place in January 2019 and an offer has been made to the preferred candidate, who has accepted the role.

SECAmb commissioning arrangements

8. These will be updated during the meeting by North West Surrey CCG, 999 lead commissioners for the counties Kent, Surrey and Sussex.

Care Quality Commission Rating

9. Following the CQC published report on the 29th September 2017, the result of which saw the Trust placed into special measures, SECAmb has been on an improvement trajectory. Further unannounced visits from the CQC saw their formal recognition of the progress that the Trust was making, achieved through a comprehensive work programme overseen by the Trust's Programme Management Office (PMO).

10. The Trust was inspected by CQC in July and August 2018 and the subsequent report published on 8th November 2018. The Trust's rating moved from 'inadequate' to 'requires improvement'.

11. The CQC also acknowledged a number of areas where the Trust has made significant progress and again rated the care given by staff to patients as good, with several other areas recognised as outstanding.

12. Some of the key improvement areas highlighted were:

- Staff cared for patients with compassion. All staff inspectors spoke with were motivated to deliver the best care possible and feedback from patients and those close to them was positive

- The Trust promoted a positive culture that supported and valued staff. Inspectors found an improved culture across the service since the last inspection. Most staff felt the culture had improved and felt able to raise concerns to their managers

- Medicines management was robust and effective with a marked improvement since the previous inspection. Inspectors found elements of outstanding medicine management, for example, the way the Trust handled Controlled Drugs. An external review also recognised the impressive turnaround in performance

- A new Well-Being Hub, which enables staff to access support in a variety of areas. The service was widely commended by staff during the inspection.

- A significant improvement in the process for investigating complaints and the quality of the Trust's response to complaints since the previous inspection

13. Following the publication of the report and its findings, the Trust will be working to continue the progress and improvements required in the 1 Must Do and 10 Should Do areas (**Annex 1)** Some key action headlines are :-

- Within the Emergency Operations Centre (EOC), the Clinical Safety and Readiness plans will form one overarching EOC plan.

- The EOC plan will include the 6 new Trust procedures identified to ensure effective systems and processes to support risk assessment activities.

- As part of the EOC plan, the effectiveness of the Clinical Safety Navigator will be monitored through clinical queue management efficacy.

- The Service Transformation and Delivery Programme has been setup to ensure that by April 2021, the best quality care and most effective response is provided for each patient first time, delivering improved response times for category 3 and category 4 calls.

SECAmb Performance

Ambulance Response Programme

14. Following the NHS England commissioned review of urgent and emergency care in 2013, it was recognised that the ambulance service response standards (England) had not been reviewed since the mid 1970's. There was a review and new standards introduced in March 2001 where we moved away from the Rural/ Urban ORCON

standards and Cat A, B and C prioritisation was introduced at this time. This has since been superseded by ARP standards.

15. In 2015, NHS England commissioned Sheffield University to undertake a study into ambulance responses. The result of this study was the introduction of the Ambulance Response Programme.

16. The Ambulance Response Programme (ARP) is a change to the way in which ambulance services (in England) receive and respond to emergency calls. On 22 November 2017, ARP went live at SECAmb.

17. A key element of ARP was the re categorisation of 999 call priorities, whilst maintaining a clear focus on the clinical needs of patients and ensuring that the right resource is dispatched **(Annex 2, Table 1)**.

Performance

18. The variance in performance for SECAmb across the three counties (Kent, Surrey, Sussex) is minimal. Since ARP implementation, SECAmb has performed close to the national average for Category 1 (C1), better than average for Category 2 (C2) (but noting the recent pressures of increased demand and the Trust proactively escalating callers in lower categories where required). Category 3 (C3) and Category 4 (C4) responses remain challenging **(Annex 2, Table 2a).**

19. Surrey County comprises of 6 clinical commissioning groups (CCGs) and 2 Integrated Care Systems, Surrey Heartlands and Frimley Health. **Table 2b** illustrates performance for December 2018 and Quarter 3 October-December 2018 across all 6 CCG's.

    a. C1 90th percentile is within target in 5 of the 6 CCG's and C2 90th percentile performance is within target in 4 of the 6 CCGs in quarter 3 and just outside target for the Guildford Operating Unit which provides coverage for those CCG's.

    b. C3 and C4 90th percentile targets were not achieved by all CCGs. Whilst this was expected for the entire Trust for Quarter 3 (based on the Demand and Capacity Review modelling), improvements are forecast and as set out in the report completed for the Demand and Capacity Review. Put simply, the Trust is meeting its obligation to deploy the required hours based on resource investment.

Cardiac and Stroke Pathways and Performance

20. SECAmb's Cardiac and Stroke Ambulance Quality Indicators (AQI's) for timeliness of response are shown in **Annex 2, Table 2c**.

    a. The Trusts performance against the stroke diagnostic bundle, in particular, has been above the national average most months and we continue to build on our success in improving care for STEMI (Acute ST-Elevation Myocardial Infarction) patients to bring our performance above the national average.

    b. Since April 2018, the Trust has also delivered sustained improvements in the proportion of patients who have a ROSC (Return of Spontaneous Circulation) when they arrive at hospital. The timeliness of care that is delivered to patients who are suffering stroke and STEMI is consistently quicker than the national average.

c. The Trust has also been highest performing in the country for the sepsis and post-ROSC care bundles, and continues to perform well above the national average.

21. On the 9th January 2017, the Royal Surrey County Hospital ceased to provide a Hyper Acute Stroke Unit (HASU). The change coincided with a countywide consultation, which stated that Surrey needed to reduce its stroke units, in order to benefit from higher activity, associated investment and enhanced patient outcomes. The emergency change continued and commissioners modelled a 60/40 split of the activity to Frimley Park Hospital (FPH) and Ashford St Peter's Hospital (ASP) respectively.

22. SECAmb have been working with crews and partners to enable this significant change. Early learning to direct more patients to ASP was that it is critical to promote the benefits of the stroke reconfiguration, to tackle the misconception with regard to travel time and to encourage a move away from historic operational practices based around SECAmb's Operating Unit (OU) boundaries. A communications programme was put into effect to relay these key messages.

23. In April 2018, a review showed that SECAmb's stroke response in the area of Guildford and Waverley is good, especially for an area with a large rural geography. The average response time for stroke patients in the Guildford and Waverley CCG was between 10 and 13 mins where SECAmb are required to have a response of 18 minutes or less. This was also the case in the southern area of Guildford and Waverley, for example in Haslemere the average response time for stroke patients (of which there were 6) was 18 mins.

24. The call to door[2] performance was shown to be slightly higher than the regional target, with an average performance for the area being between 1 hr and 1hr 10 mins. This was largely due to two factors; on scene times and longer travel times to HASU's and can be improved by a focus on reducing on scene times and faster door to treatment times at hospital. SECAmb are working on specific on-scene time improvements with a local focus initiative ongoing. There have also been recent access improvements to the ASP HASU, which differs for a complicated or uncomplicated stroke patient. The December 18 operational instruction to reinforce this pathway change is shown in **Annex 2 Table 2c**.

Demand and Capacity Review

25. The Demand and Capacity review was set to review resource requirements to deliver ARP standards. Once costed, this demonstrated the income / investment required for the Trust as between c. £203m to £208m for 2019-20 and c. £215m to £219m for 2020-21 (£40m investment per annum cf 2016/17).

26. During 2017- 2019, following the identification of a gap in funding, for SECAmb to deliver its existing model and achieve all performance targets, Commissioners and SECAmb jointly commissioned (with the support of NHS England and NHS

[2] the total length of time from receiving a 999 call, dispatch of an ambulance, treatment on scene, transportation to HASU / ASU and ending in patient handover)

Improvement), Deloitte and ORH Ltd. [3] (ORH) to undertake a review of existing and future operating models.

27. The approach from Deloitte and ORH was in the form of a 'Demand and Capacity' review to understand the relationship between resources, performance, and finances. The focus of the review was on two operating models: 1) Paramedic Led Ambulance Model and 2) The Targeted Dispatch Model. Both identified a requirement to increase not only the number of front line staff, but also the fleet resource.

28. The conclusion of this review to recommend the 'Targeted Dispatch Model', which focused on getting clinically appropriate resources to patients by using specialist paramedics in cars, paramedics on ambulances and the introduction of a lower acuity mode of ambulance to specifically support those patients that fall into C3 & C4 calls. Non-Emergency Transport (NET) vehicles have since been procured and are being rolled out across the Trust by April 2019.

29. The NET vehicles will support the Trust to improve response to patients who are not in a serious or life-threatening condition. Primarily, they will serve patients assessed by a Health Care Professional, such as a Paramedic or GP and who require non-emergency urgent transport to a healthcare facility. Additionally, all NET vehicles will be equipped with essential life-saving equipment and able to attend as a first response to life-threatening calls. The NET's will be crewed by Emergency Care Support Workers, Associate Ambulance Practitioners and Ambulance Technicians.

30. Another key element of the 'Targeted Dispatch Model' is that it builds on our work with the wider system to enable and facilitate alternatives to conveyance to an Emergency Department. That is, increase 'hear and treat' and 'see and treat' or refer into jointly developed, clinically governed, community based care pathways.

31. Work has already begun on the delivery of this model through the Service Transformation and Delivery (STAD) Programme implementation with staff recruitment and fleet procurement underway. A key part of the delivery is that Q1 2019/20 will see C1 performance achievement on a sustainable basis, and the introduction of the full model for all categories of performance, with sustainability fully achieved by Q4 2020/21.

32. In Surrey, there is a significant increase in staff and vehicles over the next 18 months including 7 NET vehicles in place by April 19. This extra resource, alongside the protected targeted dispatch model and Paramedic Practitioners tasked to focus on admission avoidance initiatives, will support increasing our 'see and treat' and referrals into alternative care pathways and reduce the time to respond to lower acuity C3 & C4 incidents.

Local Operation Unit Highlights and Transformation Initiatives

33. The Surrey County geography is covered by 3 separate Operating Units serving 6 CCG areas working within 5 Acute hospital systems. Each Acute system governs Urgent Emergency Care transformation through the local A&E Delivery Board or Integrated Care Systems (ICS) and sub groups, with which SECAmb are fully engaged to drive local initiatives to deliver system wide benefits and improved patient care.

34. **Guildford Operating Unit** : Royal Surrey County & Frimley Park Hospital systems

[3] http://www.orhltd.com/about-us/

a) In the final stages of agreement for the new April ’19 rotas. A local recruitment campaign is ongoing and assessor training in place to increase local resource. The Tongham estate works planned are to better utilise the current space available.
b) Working with the CCG and Frimley Integrated Care Teams to facilitate simplified access points to enhanced community pathways and improved patient care plans to support reduced Acute conveyances where appropriate.
c) Delivering a 6 month Joint Response Unit (JRU) pilot with Surrey Police, operating Thursday to Saturday evenings, to respond to the joint callouts (totalling 7500 per annum). In the first 2 months, 63% of these complex social cases are dealt with by JRU operatives on scene. Of the remaining 37% requiring conveyance, only 11% required high specification ambulance transportation, with the remaining appropriate for the NET vehicle transportation. Not only does this free up constrained emergency resource but reduces wait times for these incidents and so far has received 100 % positive public comment via police social media platforms.

35. **Chertsey Operating Unit** : Ashford St. Peters Hospital system
a) Staff recruitment is ongoing with the initial training course of 18 set for April 2019. Extra vehicles are already available to meet demand, ahead of new staff availability, via fulfilling rosters on overtime. The estate review work is ongoing to accommodate the increased staffing.
b) The NET vehicles have been rolled out and require the wider system communications and comprehension in order to maximise vehicle usage, especially for other Health Care Practitioner admission.
c) Working closely with Community Services and Acute Trust partners to deliver an additional Falls Response Vehicle (6 month pilot) and enhanced Frailty pathways, to reduce repeat fallers and provide an expedited Frailty assessment where needed

36. **Gatwick and Redhill Operating Unit** : East Surrey, Epsom and St. Hellier Hospital systems
a) A ‘Perfect Week’ exercise delivering enhanced system hours and clinical decision making support was trialled in Gatwick and Redhill operating unit. We are reviewing lessons learnt for wider application across Sussex and Surrey, in line with the new STAD resource application. This showed positive improved response times and reduced conveyances to East Surrey Hospital.
b) Working closely with Acute Trust partners and awaiting the formal opening of a new Rapid Assessment area at Epsom General to assist with Handover delays.
c) Working closely with Community Services to support the Epsom @ Home service for hospital avoidance.

37. **Surrey Nursing Homes focus** – working with the Surrey wide Care Home Collaborative to enable enhanced health in care homes principles and supporting the system in identification of frequent 999 call homes and outcomes.

38. **Surrey Mental Health pathways** – working closely with Surrey and Borders Partnership Foundation Trust to utilise the newly established Single Point of Access service into 24/7 enhanced crisis pathways. This is working alongside our newly appointed MH Nurses, working in our Emergency Operations Centre to better support our patients in acute mental health crisis.

SECAmb Strategic Initiatives

Five-Year Strategy

39. The Trust has developed a strategic plan for the next 5 years, 2017-22, and is focussed on the delivery of 4 strategic themes; Our People, Our Patients, Our Partners, and Our Enablers. We are currently refreshing our strategy to take account of internal and external developments since publication in July 2017 and this will be presented to the Trust Board in the next few months.

Alliances

40. On 22 November 2018, the Trust announced that it was working to form an alliance with West Midlands and South Western Ambulance Services that will see us working closely together to deliver efficiency savings to invest in front line services.

41. The alliance expects to deliver savings through initiatives such as the joint procurement of supplies, including equipment and fuel. In addition, we will work collaboratively to share best practice for the benefit of patients and staff and will also work on improving resilience between the organisations for planned events and major incidents.

42. The work will draw upon existing benchmarking and evidence from the National Audit Office investigation into ambulance services, and more recently, the report from Lord Carter into efficiency and productivity.

43. It is important to stress that there are no plans to merge services or re-structure existing operations, but the alliance will mean that the three Trusts can make every pound of taxpayers' money work as efficiently as possible.

44. This is very much the start of the process and further work will follow over the coming months through our Board and governance framework. However, by forming this partnership, we will be able to bring together the knowledge and experience of the three Trusts to explore ways to reduce variation and develop new joint initiatives.

Fleet & Estates Strategy

45. SECAmb has invested in a 101 new ambulances with a vehicle roll out programme during the next 12 months. July 2018 saw the first of 42 new ambulances, 'Mercedes Sprinters', being rolled out at a rate of 3 to 4 per week. The Trust is also in the process of trialling 16 new Fiat van conversion ambulances.

46. In addition and to further support ARP, the Trust has invested in 30 second-hand Fiat ambulances, operating as Non-Emergency Transport (NET) vehicles, which are converted to attend the lower acuity non-life threatening calls and will carry slightly different equipment. These vehicles are being introduced in a phased approach commencing mid December 2018: full operational roll out is expected to be complete by April 2019.

47. During 2019/20 further investment is planned in up to a further 50 ambulances as well as a replacement programme for the Trust's rapid response cars and 4x4 vehicles.

Hospital Handover Delays

48. SECAmb is leading on a system wide programme of work focusing on reducing ambulance hours lost at hospital sites due to handover delays. The programme is led by a Programme Director.

49. Some good progress has been made overall, with January ’19 showing a 15% decrease (1033) in hours lost >30 minute turnaround and this is equivalent to an average 185 ambulance hours (15 – 12hour shifts) lost per day in January 2019 compared to 228 ambulance hours (19 - 12hour shifts) in 2018. Whilst this is a reduction when compared to the same period last year, handover delays remain of significant concern. Most hospital sites are losing fewer hours than last year but there are some significant outliers. See **Annex 3** for a comparator tables by Surrey Hospital.

50. A key part of the work stream has been to develop, together with each acute hospital; a handover action plan to streamline the process of handover delays including best practice e.g. dedicated handover nurse and administration, Fit2Sit, front door streaming and direct conveyance to non-ED destinations.

51. A number of live conveyance reviews have also taken place where a representative from the ambulance service, hospital, primary care, community trust, and CCG have reviewed all decisions to convey to hospital with an aim to ensuring that all existing community pathways are maximised.

52. The reviews undertaken so far, have given a clear indication that community pathways are being maximised where they are in place. The results are being presented for further discussion with local system partners in order to explore new community pathways, where required.

53. Peer reviews looking at the handover process at individual sites have also taken place at some hospitals, where the Chief Operating Officer from another acute hospital, supported by a member of the Emergency Care Intensive Support Team (ECIST), visits another hospital and reviews the ambulance pathway through the department. The peer reviews have been positively received and have been a good way to share best practice across hospital sites.

Conclusions:

54. SECAmb requests the Health Integration and Commissioning Select Committee to note the:

    a. Recent CQC report and improved rating, alongside the ongoing areas of focus.
    b. Trust’s current Performance rating and continued improvement plans.
    c. Demand and Capacity review recommendations and resulting Service Transformation and Delivery, and Emergency Operations Centre programmes.
    d. Local operational updates and transformation initiatives supporting local health and social care systems improvement.
    e. Ongoing strategic direction and proposed Alliances work.
    f. Ongoing investment in key personnel and fleet resources.
    g. Continued focus on working with our Acute Trusts partners to reduce handover delays, especially in times of escalation.

Recommendations:

For the Health, Integration and Commissioning Select Committee to:

a. note the report and make recommendations.

Next steps:

To be identified as needed post presentation.

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ANNEXES

ANNEX 1: CQC REPORT SUMMARY FINDINGS – 8th November 2018

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- In both the emergency operations centre (EOC) and emergency and urgent care (EUC) we rated safe, effective, responsive and well-led as requires improvement and rated well-led in resilience as requires improvement.
- We rated safe, effective and responsive in the trust's resilience core service as good. We rated caring as good across all three core services.
- In rating the trust, we took into account the current ratings of the 111 service, which was not inspected this time.
- We rated well-led for the trust, overall, as requires improvement.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

1 South East Coast Ambulance Service NHS Foundation Trust Inspection report 08/11/2018

Outstanding practice

Emergency Operations Centre

- Support for maternity patients was excellent. A new pregnancy advice and triage line for pregnant women had been introduced within the Crawley EOC.

Emergency and Urgent Care

- The Crawley triage scheme, which had led to a reduction in conveyancing to hospital for people with mental health conditions from 53% to 11%.
- We found elements of outstanding medicine management, for example the way the trust handled Controlled Drugs (CD's). We found suitable audit and quality control processes to ensure the high standards achieved by the organisation were continuously monitored.
- The trust initiative to provide physical and mental health support for staff through the 'wellbeing hub' was widely commended by staff during the inspection.
- There was a multidisciplinary multiagency approach to training in the Kent area. This meant staff were training to deal with unexpected situations should they occur.

- Brighton station had a dedicated homeless lead who took responsibility for and oversight of this vulnerable group. This role included undertaking outreach work, as well as working with local services to meet the needs of these patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve services in both the emergency operations centre and in emergency and urgent care.

- The trust **must ensure** that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

Action the trust SHOULD take to improve the emergency operations centre

- The trust **should ensure** they take action to continue to have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.
- The trust **should ensure** they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.
- The trust **should ensure** there are a sufficient number of clinicians in each EOC to meet the needs of the service.

Action the trust SHOULD take to improve emergency and urgent care

- The trust **should ensure** the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.
- The trust **should ensure** that maps in all vehicles are current, up to date and replaced regularly.
- The trust **should ensure** that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.
- The trust **should ensure** that pain assessments are carried out and recorded in line with best practice guidance.
- The trust **should ensure** response times for category three and four calls is improved.
- The trust **should consider** producing training data split by staff group and core service area for better oversight of training compliance.

Action the trust SHOULD take to improve Resilience

- The trust **should ensure** they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.

ANNEX 2: Ambulance Response Programme and SECAmb Performance

Table 1:

ARP Performance Categories

Category	Types of Calls	Response Standard	Likely % of Workload	Response Details
Category 1 (Life-threatening event)	**Previous Red 1 calls and some Red 2s including** • Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with breathing problems	**7 Minute response** (mean response time) **15 Minutes 9 out of 10 times** (90th Centile)	Approx. 100 Incidents a day **(8%)**	Response time measured with arrival of first emergency responder Will be attended by single responder and ambulance crews
Category 2 (Emergency, potentially serious incident)	**Previous Red 2 calls and some previous G2s including** • Stroke Patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	**18 minute response** (mean response time) **40 minute response** (90th centile)	**(48%)**	Response time measured with **arrival of transporting vehicle** (or first emergency responder if patient **does not** need to be conveyed)
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	**Maximum of 120 minutes** (120 minutes 90th centile response time)	**(34%)**	Response time measured with arrival of **transporting vehicle**
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain	**Maximum of 180 minutes** (180 minutes 90th centile response time)	**(10%)**	May be managed through hear and treat Response time measured with **arrival of transporting vehicle**

Table 2a: National ARP Ambulance Quality Indicators (AQI's) December 2018

	C1	Mean
	England	**00:07:06**
1	London	00:06:17
2	North East	00:06:29
3	West Midlands	00:06:48
4	South Western	00:06:49
5	South Central	00:06:55
6	Yorkshire	00:07:03
7	East of England	00:07:31
8	North West	00:07:41
9	South East Coast	00:07:44
10	East Midlands	00:07:45
11	Isle of Wight	00:09:40

	C1	90th
	England	**00:12:24**
1	London	00:10:29
2	North East	00:11:17
3	West Midlands	00:11:49
4	Yorkshire	00:12:15
5	South Western	00:12:18
6	South Central	00:12:26
7	North West	00:12:55
8	East of England	00:13:42
9	East Midlands	00:13:50
10	South East Coast	00:14:13
11	Isle of Wight	00:18:34

	C2	Mean
	England	**00:22:22**
1	West Midlands	00:12:29
2	South Central	00:17:13
3	Isle of Wight	00:18:22
4	South East Coast	00:20:24
5	London	00:20:39
6	Yorkshire	00:21:03
7	East of England	00:22:34
8	North West	00:24:52
9	North East	00:26:35
10	South Western	00:27:24
11	East Midlands	00:31:20

	C2	90th
	England	**00:46:21**
1	West Midlands	00:22:57
2	South Central	00:34:54
3	Isle of Wight	00:36:37
4	South East Coast	00:38:59
5	London	00:43:20
6	Yorkshire	00:44:17
7	East of England	00:46:13
8	North West	00:53:44
9	North East	00:54:50
10	South Western	00:58:08
11	East Midlands	01:06:31

	C3	Mean
	England	**01:06:07**
1	West Midlands	00:36:15
2	South Central	00:54:22
3	Yorkshire	00:54:59
4	London	01:00:25
5	Isle of Wight	01:02:05
6	East of England	01:06:25
7	South Western	01:10:06
8	North West	01:11:02
9	East Midlands	01:31:53
10	North East	01:40:55
11	South East Coast	01:42:37

	C3	90th
	England	**02:36:23**
1	West Midlands	01:23:00
2	South Central	02:10:56
3	Yorkshire	02:15:22
4	Isle of Wight	02:22:50
5	London	02:27:51
6	East of England	02:38:35
7	South Western	02:43:07
8	North West	02:50:33
9	East Midlands	03:39:09
10	North East	03:53:19
11	South East Coast	03:57:30

	C4	Mean
	England	**01:24:13**
1	West Midlands	00:51:41
2	East Midlands	01:06:19
3	Yorkshire	01:08:40
4	East of England	01:15:38
5	London	01:15:44
6	South Central	01:15:47
7	North East	01:27:05
8	North West	01:38:00
9	South Western	01:40:51
10	Isle of Wight	01:45:39
11	South East Coast	02:08:29

	C4	90th
	England	**03:09:39**
1	West Midlands	02:01:16
2	Yorkshire	02:43:07
3	East Midlands	02:50:27
4	London	02:52:36
5	South Central	02:56:59
6	East of England	03:06:17
7	North West	03:24:46
8	South Western	03:40:21
9	North East	03:44:09
10	Isle of Wight	04:04:33
11	South East Coast	04:40:58

Table 2b:

SECAmb Performance for December 2018

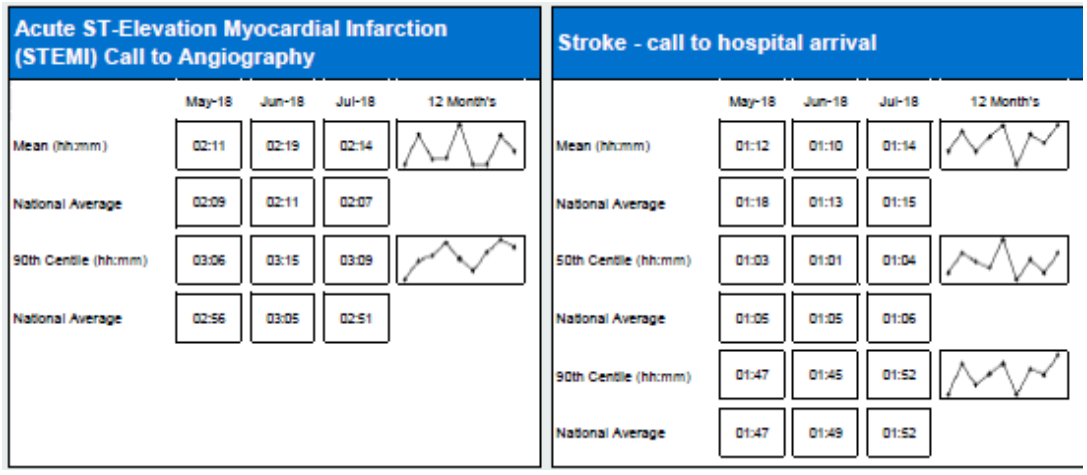
Dec 18 @ 08/01/2019	CCG	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
NHS East Surrey CCG	Surrey	00:07:55	00:13:29	00:19:33	00:38:04	03:09:14	03:40:20
NHS Guildford and Waverley CCG	Surrey	00:08:49	00:15:02	00:21:39	00:41:05	03:55:16	03:37:47
NHS North East Hampshire and Farnham CCG	Surrey	00:06:46	00:10:46	00:21:02	00:38:40	04:05:28	05:11:25
NHS North West Surrey CCG	Surrey	00:08:40	00:13:20	00:18:38	00:33:36	04:11:13	04:46:53
NHS Surrey Downs CCG	Surrey	00:07:28	00:13:27	00:20:02	00:37:06	03:22:26	03:29:26
NHS Surrey Heath CCG	Surrey	00:07:06	00:11:30	00:19:16	00:38:24	04:13:23	05:02:12
Surrey Heartlands STP*	SH STP	00:08:19	00:14:01	00:19:47	00:36:58	03:50:08	04:40:18
SECAmb commissioned Totals	**SECAmb**	00:07:43	00:14:14	00:19:58	00:39:09	03:57:17	04:41:20

SECAmb Performance for Quarter 3: October to December 2018

Oct-Dec 2018 @ 08/01/2019	CCG	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
NHS East Surrey CCG	Surrey	00:07:39	00:14:00	00:18:54	00:36:35	02:39:35	03:39:23
NHS Guildford and Waverley CCG	Surrey	00:08:48	00:17:11	00:22:07	00:42:06	03:45:15	03:46:00
NHS North East Hampshire and Farnham CCG	Surrey	00:06:56	00:11:20	00:21:07	00:40:51	03:50:31	04:58:49
NHS North West Surrey CCG	Surrey	00:08:11	00:13:10	00:18:29	00:34:49	03:48:07	04:53:12
NHS Surrey Downs CCG	Surrey	00:07:38	00:13:59	00:18:56	00:34:27	02:53:17	03:16:59
NHS Surrey Heath CCG	Surrey	00:07:06	00:11:25	00:19:21	00:39:19	03:43:14	04:56:33
Surrey Heartlands STP*	SH STP	00:08:09	00:14:15	00:19:27	00:36:24	03:32:25	03:46:56
SECAmb commissioned Totals	**SECAmb**	00:07:35	00:14:03	00:19:36	00:37:45	03:27:04	04:30:16
STAD Q3 trajectories	**SECAmb**	00:08:31	00:17:12	00:15:49	00:30:42	03:13:36	05:08:30
STAD Q4 trajectories	**SECAmb**	00:07:35	00:15:18	00:14:53	00:29:54	00:58:42	01:42:18

Table 2c:

SECAmb Clinical Safety Indicators - Cardiac and Stroke Response Timeliness



SECAmb Operational Bulletin: Fast+ Stroke patients to Ashford St. Peter's Hospital

Op271%20V1%20-%20FAST+%20Stroke%2

ANNEX 3: Hospital Handover Delay Reporting

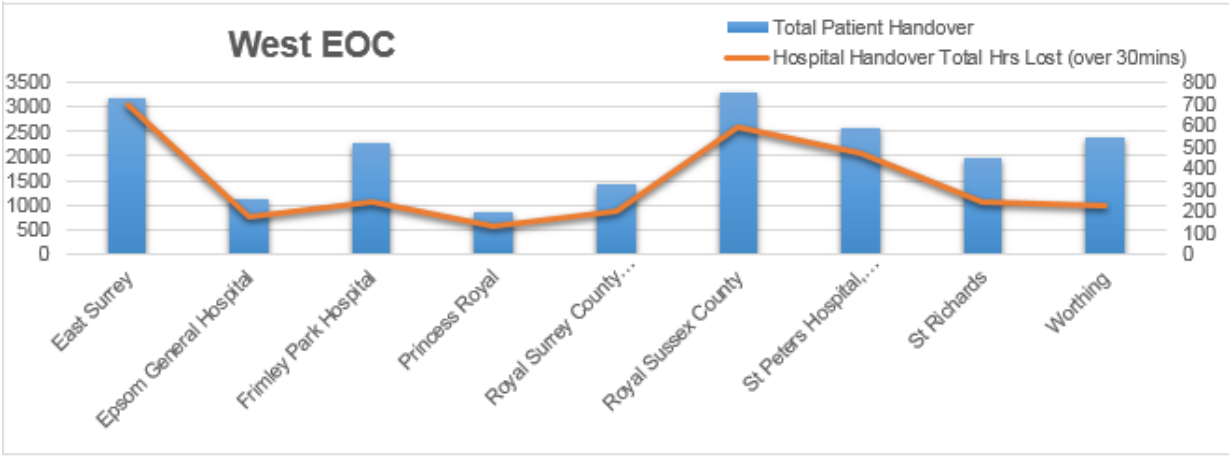
Individual monthly table – total hours lost >30 minute turnaround January 2019

Area	January 2016 (hh)	January 2017 (hh)	January 2018 (hh)	January, 2019 (hh)	Increase from January '2018 vs January '2019 (hh)	Increase from January '2017 vs January '2019 (hh)	Increase from January '2016 vs January '2019 (hh)
SECAMB (Amb Hours Lost at Hosp >30min)	4583	7950	7085	6052	-15%	-24%	32%
Surrey Area	1449	1968	2113	1780	-16%	-10%	23%
East Surrey	410	609	742	686	-8%	13%	67%
Epsom General Hospital	113	143	224	178	-20%	25%	58%
Frimley Park Hospital	299	435	380	244	-36%	-44%	-18%
Royal Surrey County Hospital	300	289	221	204	-7%	-29%	-32%
St Peters Hospital, Chertsey	328	493	547	468	-14%	-5%	43%

Cumulative monthly table hours lost >30 minute turnaround April 2018 – January 2019

Area	2014-15 (to specified month)	2015-16 (to specified month)	2016-17 (to specified month)	2017-18 (to specified month)	2018-19 (to specified month)	% Growth From 2017-18 to 18-19	% Growth From 2016-17 to 18-19	% Growth From 2015-16 to 18-19	% Growth From 2014-15 to 18-19
SECAMB (Hours Lost)	34221	36079	57508	56780	46695	-18%	-19%	29%	36%
Surrey Area	10308	11772	16124	16706	12526	-25%	-22%	6%	22%
East Surrey	2880	4143	4526	5588	3230	-42%	-29%	-22%	12%
Epsom General Hospital	706	687	1148	1538	1272	-17%	11%	43%	68%
Frimley Park Hospital	1985	2279	3389	3241	2313	-29%	-32%	1%	17%
Royal Surrey County Hospital	1745	1851	3331	2198	1683	-23%	-49%	-9%	-4%
St Peters Hospital, Chertsey	2942	2612	3730	4142	4028	-3%	8%	54%	37%

January 2019 – Hospital: Patient Handover Activity and Total Hours Lost



Health, Integration and Commissioning Select Committee

8 March 2019

Draft Joint Health and Wellbeing Strategy for Surrey

Purpose of report:
This report provides the Select Committee with the opportunity to consider and comment on the draft Joint Health and Wellbeing Strategy for Surrey.

Introduction:

Local context

1. Over the spring and summer of 2018, Surrey County Council engaged with residents, communities and partners across the county to understand what Surrey should look like by 2030. Informed by those conversations, a new community for vision for Surrey was created:

   'By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.'

2. In light of the new community vision, and the vital role people and organisations in the health and care system have to play in its delivery, partners initiated a rigorous process for developing a new and fully aligned Joint Health and Wellbeing Strategy (JHWS) for Surrey. The Surrey Health and Wellbeing Board are responsible for the production of the JHWS – the Board will approve the final strategy and will oversee its delivery and implementation. The draft JHWS, annexed to this report (Annex one), has been published as a draft for comment to test the priorities and ambition within it as part of a four week engagement period before being finalised.

3. The primary health and care partnerships across Surrey are the two Integrated Care Systems (ICS) in Surrey Heartlands and Frimley, and the Sustainability and Transformation Partnership (STP) covering East Surrey (and Sussex) – as a Surrey-wide document, partners from all three have been involved in the development of the new JHWS.

National context

4. Nationally, a key policy focus over recent years from the NHS has been on developing new models of out of hospital care (driven by the NHS five year forward view document) and the creation of new partnerships bringing together NHS providers and commissioners, with local authorities and other partners encouraging a more place-based approach to planning and delivery (Sustainability and Transformation Partnerships or in more advanced areas, Integrated Care Systems).

5. In June 2018, the government announced a new five-year funding settlement for the NHS representing a 3.4% average real-terms annual increase in NHS England's budget from 2019/20 to 2023/24 (this equals a £20.5 billion increase over the period).

National NHS bodies were asked to develop a 10 year plan to secure this funding and in January 2019, the NHS published it Long Tern Plan (LTP).

6. The LTP's aim is '*to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment*'. The LTP also placed significant emphasis on the role of ICS's asking each to develop its own 5 year plan by the autumn of 2019. A summary of the LTP is annexed to this report (Annex two).

7. The local partnerships asked to respond to the NHS LTP in Surrey are the two ICSs and the STP mentioned above. As the Surrey Heartlands ICS is entirely within the county of Surrey, the Surrey JHWS will form the core of its response to the NHS LTP (with supplementary Surrey Heartlands specific information submitted alongside it). The Surrey JHWS will also form part of the separate submissions made by both East Surrey and Sussex STP and Frimley ICS in their responses to the NHS Long-Term plan.

8. A Green Paper on social care is due to be published later this year with indications it will cover integration with health and other services, carers, workforce and technological developments, with an overall aim of ensuring that the care and support system is sustainable in the long term. Partners locally will review the contents of the Green Paper once published to ensure alignment with the implementation of the Health and Wellbeing Strategy.

Draft Joint Health and Wellbeing Strategy

9. The draft Joint Health and Wellbeing Strategy (JHWS) sets out the challenges facing the Surrey health and care system as part of the case for change and describes the priorities for the system focusing on the wider determinants of health to create long-term and generational change for the population. Set out below is an executive summary of the JHWS (Annex one) highlighting what can be found in each of the sections of the document. Links to the JHWS appendices are provided where additional detail can be found.

Background / foreword (JHWS pages 3-4)

10. The background and foreword provide an introduction to the Strategy giving context describing the ambition and strategic intent of the document. In summary:

    - The people and organisations in the health and care system will play a vital role in the delivery of the 2030 community vision for Surrey. Recognising this, partners initiated the development of the new 10 year JHWS for Surrey.
    - The JHWS is the product of unprecedented collaboration between the NHS, Surrey County Council, district and borough councils and our wider partners, including the voluntary and community sector and the police.
    - The strategy focusses on the importance of prevention and addressing root causes of poor health and wellbeing – including things like poor housing and the environment – and not simply on treating the symptoms. It is intentionally ambitious.
    - It states 'We want the people of Surrey to live longer, healthier lives. We believe that people should be supported to look after themselves and those they care for, and have access to services when they need them. And we want to deliver better health and wellbeing outcomes within our budget'.
    - The strategy focuses on a single set of agreed priorities for the county, in particular where change can be effected as a partnership. It is not meant to include

everything, and therefore doesn't cover sector specific, organisational or local plans although these will all need to be aligned to this overarching work.

Context and case for change (JHWS pages 5-8)

11. This section of the JHWS describes the county of Surrey and summarises the evidence that has been reviewed and used to understand the current state of health and wellbeing in Surrey (using the life phases of Start Well, Live Well, and Age Well as a framework). The Surrey Joint Strategic Needs Assessment is named as a comprehensive source of information to inform the strategy. In summary:

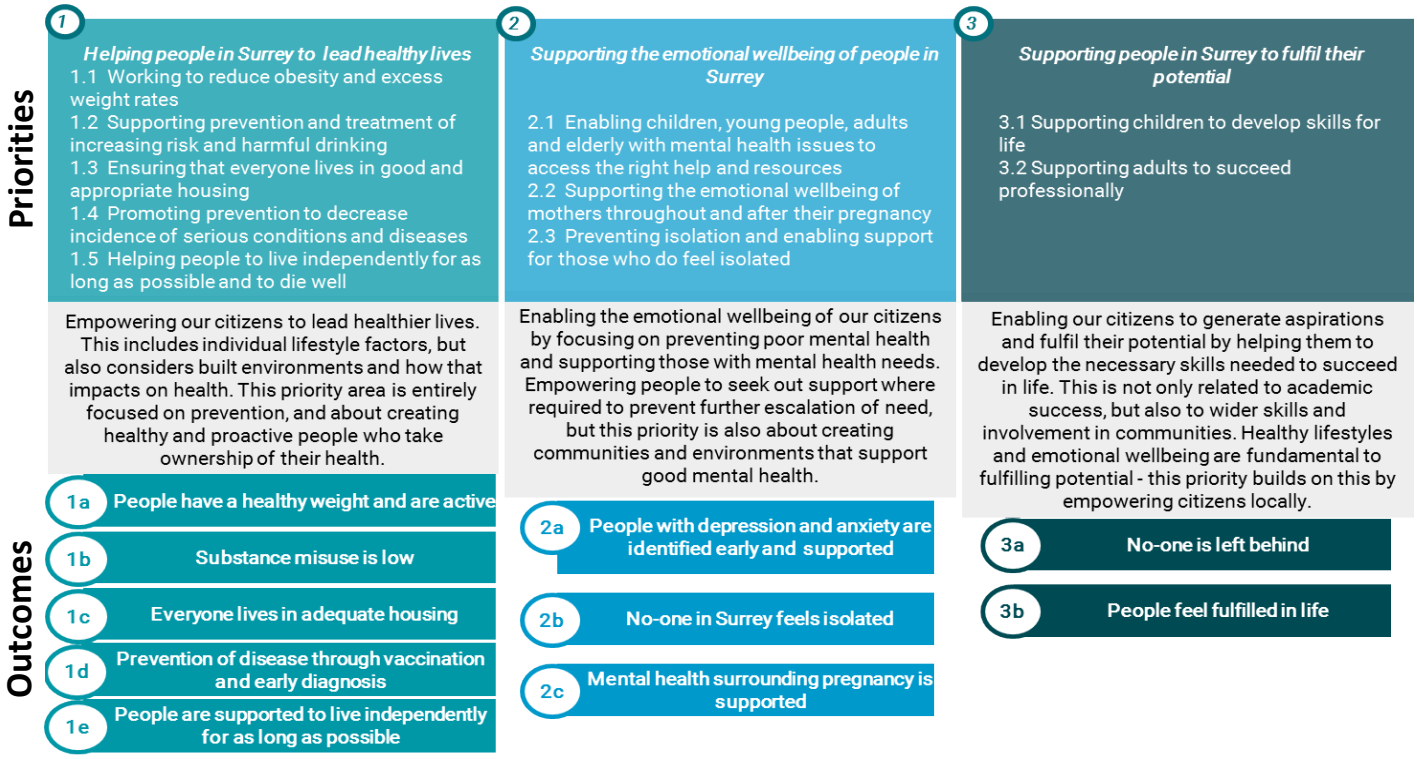
    - Public services in Surrey and across the country are under growing pressure, with continued funding constraints, rising expectations and increasing demand. Surrey's population is older than the national average and this is expected to increase. By 2030 over 22% of Surrey's residents will be aged 65 and over, and more than 30% are already living with a long term condition.
    - Although on the whole Surrey is widely perceived as a 'healthy and wealthy' county, it is not without its share of challenges. For example, it is estimated that 10,600, 5 to 15 year-olds in Surrey have a mental health disorder. Similarly, there is considerable variation in deprivation, with over 23,000 children in Surrey living in poverty, which is linked to poor health and wellbeing outcomes for them and their parents.
    - Health and wellbeing is at the heart of a prosperous society. The evidence is clear; shifting towards a place based approach to deliver key priorities will result in a more effective and efficient service.
    - Alongside the data we have about people's health and wellbeing, citizen engagement has and will continue to form a vital role in the design and delivery of the JHWS.

12. Appendix two to the JHWS (priority scorecards) provides greater detail and insight into the data that was reviewed in helping determine the priorities – these scorecards were developed for 12 emerging priority areas, summarising the information gathered both from external research and stakeholder engagement. They were used at a system-wide workshop to discuss and debate which of the 12 areas should be prioritised first. They provide a clear picture to understand the current state of Surrey and where there are opportunities for improvement, or a case for change.

Priorities for Surrey (JHWS pages 9-12)

13. The 'Priorities for Surrey' section sets out the priorities that have been identified and the groups of the population that the Strategy is aimed at. It also summarises the approach taken to identifying priorities. In summary:

    - The Strategy describes the evidence based approach taken so that the focus is on Surrey's greatest challenges and, where appropriate, target the groups of the population that need additional help to achieve their target outcomes.
    - Surrey will focus on three interconnected priorities described with outcomes in the diagram below:
        - Leading healthy lives;
        - Having good emotional wellbeing; and
        - Fulfilling potential.



- To avoid any groups of the population being left behind, Surrey will focus on tackling these priorities across the entire population, as well as within some specific groups of people which are often overlooked or most at risk. Those population groups are:
  - The general population
  - Children with special education needs and disabilities (SEND) and adults with learning disabilities and / or autism
  - Young and adult carers
  - People who need support to live with illness, live independently, or to die well
  - Deprived or vulnerable people
- These priorities and target population groups have been identified based on extensive data and benchmarking analysis as well as stakeholder engagement across the county. They focus on prevention in its earliest form, and on providing the right 'place' for the population to thrive and reach their full potential.

14. Appendix Four of the JHWS describes in more detail how the measures and targets for each of these population groups were developed, and includes an outcomes matrix illustrating the metrics being used to track progress against each priority and the population groups.

Priority population groups (JHWS pages 13-27)

15. The JHWS describes the target outcomes for each population group (identified above). Fulfilling potential, leading healthy lives, and having good emotional wellbeing have different meanings and implications depending on the environment and conditions for each individual. Whilst the system-wide priorities remain the same for each population

group, the definition of success has been adapted to each target population group. This is to avoid the overall positive outcomes for the wider population masking the existing areas for improvement and poor outcomes for specific groups.

16. Identifying how the system-wide outcomes relate to each population group helps enable partners to measure and track success more clearly. In addition, this puts a specific focus on those groups who may have been left behind in the past, or may not have had their outcomes measured or addressed in a way that delivers the greatest impact.

17. For each population group this section of the JHWS describes:

    - A short definition of the population group;
    - The difference delivery of the JHWS is intended to make through some key measures of success (this includes 10 year outcome targets);
    - Example initiatives or programmes that have been identified – these are not the explicit initiatives that will be implemented but provide a view of how outcomes may be achieved and how learning from best practice elsewhere can be used to deliver improved outcomes; and
    - A description of how partners will need to work together differently to achieve our ambitions ('building capabilities').

18. Appendix six of the JHWS sets out clearly the measures of success against each of the outcomes under the population group headings. The use of further measures identified through recent engagement activity is also being explored – a summary of these additional measures is also captured in Appendix Six.

System capabilities (JHWS pages 28-32)

19. The final section of the JHWS describes a set of 'system capabilities' that will need to be developed across Surrey to achieve the target outcomes and describes how the different parts of the Surrey system will need work together and collaborate to be successful. In summary, the eight system-wide capabilities identified in the JHWS are:

    - Community development - clear channels are needed through which local communities and residents can be engaged;
    - Governance - decision making that is simple, collaborative and unambiguous, whilst being representative of all partners in Surrey to support delivery;
    - Estates - using a one-Surrey estates ethos to consolidate collective estates across the patch;
    - Workforce and culture - a modern and radical workforce approach that will create and develop a future workforce equipped to manage future demands and work effectively and collaboratively to deliver the outcomes set out in the JHWS;
    - Programme and performance management - programme management and performance management capabilities which can manage multi-partner programmes and delivery effectively across Surrey;
    - Digital and technology - our information systems working together within / across organisational boundaries; greater collaboration; and better visibility and transparency over performance data;
    - Intelligence - data sharing and intelligent analytics which underpin effective decision-making and provide clarity on system performance; and

- Devolution and alignment of incentives - devolution affords freedoms and flexibilities which can allow the Surrey system to align incentives across partners and eliminate financial and performance barriers to collaboration.

20. Appendix seven of the JHWS describes the system capabilities in more detail and provides an indicative timeline for implementation.

Approach to developing the JHWS

21. Partners have followed a rigorous and in depth process to fully understand the challenges the system is facing, the experience and outcomes current secured for Surrey's residents, and identified those priority areas that will have the biggest impact on the health and wellbeing of the population.

22. This work has included:

- a thorough review of evidence and population health needs – benchmarking data and root-cause analysis into wider socio-economic factors impacting on people's health and wellbeing;
- listening to experts and key stakeholders from across the system – over 150 people's views gathered through more than fifty 1:1 meetings and fifteen focus groups and workshops;
- two 'whole-system' workshops bring together over 100 people from partner organisations across Surrey to help shape the draft JHWS;
- a review of existing strategies and plans learning from what is already in place; and
- listening to the views of people in Surrey – residents, patients, those who use health and care services – using for example the feedback gathered through the Surrey Residents Survey; the Connected Care Survey; the Mental Health Survey; deliberative research carried out with residents by the Surrey Heartlands ICS; and the feedback captured as part of the most comprehensive resident engagement exercise Surrey County Council has embarked upon in the development of the Surrey 2030 vision.

23. Appendix three of the JHWS includes a summary of the approach to citizen engagement and a list of all the partners and individuals engaged in the development of the strategy.

24. Whilst the approach taken to developing the JHWS has been robust – based on evidence, resident / patient views and the expertise of professionals working across the system – the Health and Wellbeing Board were keen to publish as a draft to help test that the evidence has been translated into a set of priorities and ambitions that are clearly understood and recognised. The draft JHWS has been published on the 'Surrey Says' engagement website (https://www.surreysays.co.uk/adult-social-care-and-public-health/hwbstrategy/) to enable people to comment on the priorities, population groups identified and level of ambition set and a summary of the feedback received will be presented to the Health and Wellbeing Board at their meeting on 4th April 2019 where the Board will be asked to approve any changes to the draft for it to be finalised and published.

25. Alongside publication of the draft JHWS, work is ongoing to:

- finalise finance and activity modelling intended to show the impact delivering the strategy will have on the finances of the health and care system; and
- finalise the supplementary Surrey Heartlands specific information that will be used alongside the JHWS to meet the planning requirements of the NHS LTP.

26. Once these have been completed, appendices and supporting documents will be updated / published with the JHWS.

Governance

27. The Surrey Health and Wellbeing Board are responsible for the production of the JHWS – the Board will approve the final strategy and will oversee its delivery and implementation.

28. To support the delivery of the new JHWS, the Board has recently agreed to widen its membership to reflect a more place based membership, and to reflect the wider determinants of health focus of the JHWS. The changes see a shift from NHS organisational representation, to representation from each of the six 'places' across Surrey (based on CCG geographical footprints) and from each of the ICS/STPs, together with new representation from the housing sector, Surrey University, Local Enterprise Partnership, and mental health service providers.

29. A key part of the next phase of work being undertaken will be to work through each of the priorities in the new JHWS - agreeing how each will be delivered and what programme management arrangements need to be established (using existing groups and mechanisms where it makes most sense). The Board will also agree how it will keep oversight of each of the priorities to support and ensure delivery.

Conclusions:

30. The draft JHWS is the product of unprecedented levels of collaboration between partners across Surrey and a robust and rigorous process to identify a new set of priorities to improve the health and wellbeing of Surrey's population based on evidence, analysis, the views of experts and key stakeholders, and feedback from residents.

31. This report and draft Strategy is presented to the Committee during an engagement period before the final version is presented to the Health and Wellbeing Board for approval.

Recommendations:

32. The Committee are asked to:

I. Review the draft Joint Health and Wellbeing Strategy (JHWS) for Surrey;
II. Provide comment on the draft JHWS to be considered by the Surrey Health and Wellbeing Board when it is asked to approve the final Strategy at its meeting on 4 April 2019; and
III. Consider and agree how the Committee will scrutinise the implementation of the JHWS.

Next steps:

33. The next steps for the development of the strategy are:

- 27th February - 27th March 2019 – JHWS engagement period

- 4th April 2019 – Surrey Health and Wellbeing Board received a summary of the feedback from the engagement period and agrees any changes to the draft JHWS
- April 2019 – final JHWS published

Report contact: Justin Newman, Devolution Programme Director, Surrey County Council / Surrey Heartlands ICS

Contact details: justin.newman@nhs.net

Sources/Background papers:
Annex one – Draft Joint Health and Wellbeing Strategy
Annex two – Summary of the NHS Long Term Plan

Appendices to the draft Joint Health and Wellbeing Strategy (mentioned in the report) can be found at: https://www.surreysays.co.uk/adult-social-care-and-public-health/hwbstrategy/

DRAFT FOR ENGAGEMENT

SURREY HEALTH AND WELLBEING STRATEGY

DELIVERING THE COMMUNITY VISION FOR SURREY

V.2. 25-02-18

CONTENTS PAGE

Supporting appendices

FOREWORD

I am delighted to present this ten year Health and Wellbeing Strategy for Surrey. It is the product of unprecedented collaboration between the NHS, Surrey County Council, district and borough councils and our wider partners, including the voluntary and community sector and the police.

We want the people of Surrey to live longer, healthier lives. We believe that people should be supported to look after themselves and those they care for, and have access to services when they need them. And we want to deliver better health and wellbeing outcomes within our budget.

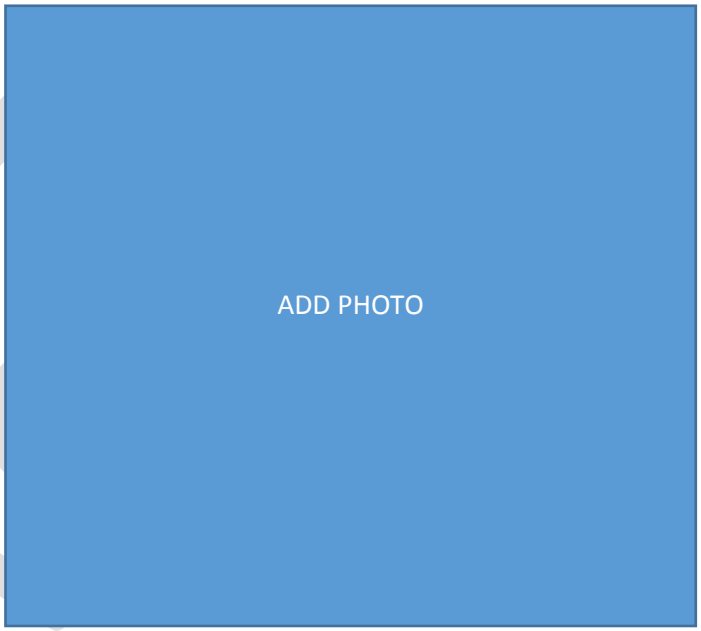
This strategy sets out how we can work together with our local communities to transform services across Surrey to achieve these aims.

Our strategy focuses specifically on the opportunities we want to work on together as a partnership. Delivering it will play a crucial part in achieving the '*Community Vision for Surrey in 2030*' which was the result of significant engagement with the Surrey population last year. It will also support the delivery of local health and care plans, how we respond to the NHS Long-Term Plan* and individual organisational strategies and plans (which include specific priorities that organisations will focus on themselves).

We have used a robust methodology to arrive at a set of priorities that all partners across Surrey recognise and support. We are committed to making a real change for the next generation by focusing on these areas and on those groups within the population who need more support.

We have been talking to our citizens about these issues for several years, and the ideas put forward in this document build on those discussions. This plan is only the first step in engagement with local communities, and acknowledges the importance of engaging further with the Surrey population if this strategy is to be truly meaningful.

We look forward to discussing our plans with you further.



Tim Oliver

Chair of the Surrey Health and Wellbeing Board & Leader of Surrey County Council

***** On behalf of each of our health and care systems; the Frimley and Surrey Heartlands Integrated Care Systems, and the Sussex and Surrey Sustainability and Transformation Partnership.

BACKGROUND

Over the spring and summer of 2018, Surrey County Council engaged with residents, communities and partners across the county to understand what Surrey should look like by 2030. Informed by these conversations, a shared vision for Surrey has been created:

> *By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.*

Our ambitions for people are:

- Children and young people are safe and feel safe and confident.
- Everyone benefits from education, skills and employment opportunities that help them succeed in life.
- Everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing.
- Everyone gets the health and social care support and information they need at the right time and place.
- Communities are welcoming and supportive, especially of those most in need, and people feel able to contribute to community life.

Our ambitions for our place are:

- Residents live in clean, safe and green communities, where people and organisations embrace their environmental responsibilities.
- Journeys across the county are easier, more predictable and safer.
- Everyone has a place they can call home, with appropriate housing for all.
- Businesses in Surrey thrive.
- Well-connected communities, with effective infrastructure, that grow sustainably.

In light of the new community vision and the vital role people and organisations in the health and care system play in its delivery, partners initiated the development of a new Joint Health and Wellbeing Strategy for Surrey. This involved partners coming together to drive real change in how Surrey's residents are enabled and supported to achieve better health and wellbeing outcomes. The strategy recognises the importance of addressing root causes of poor health and wellbeing – including things like poor housing and the environment – and not simply focusing on treating the symptoms. It is intentionally ambitious.

The strategy sets out Surrey's priorities for improving outcomes across the population and a set of targets for the next 10 years. It identifies specific groups of people who suffer higher health inequalities and who may therefore need more help. And outlines how we need to collaborate so we can drive these improvements at the pace and scale required.

We recognise that the county of Surrey sits across three health and care partnerships (the Surrey Heartlands and Frimley Integrated Care Systems (ICSs), and the Sussex & East Surrey Sustainability and Transformation Partnership). These, along with other local partnerships, will be the key vehicles for delivery with no need for any additional governance or new structures.

The strategy focuses on a single set of agreed priorities for the county, in particular where we can effect change *as a partnership*. It is not meant to include everything, and therefore doesn't cover sector specific, organisational or local plans although these will all need to be aligned to this overarching work. As the Surrey Heartlands ICS is entirely within the county of Surrey, this strategy will form the core of its response to the NHS Long-Term plan (with additional information which is included in Appendix One). This strategy will also form part of the separate submissions made by both East Surrey and Sussex STP and Frimley ICS in their responses to the NHS Long-Term plan.

CONTEXT AND CASE FOR CHANGE

A picture of Surrey

Over 1.1 million people live in the county of Surrey, interacting with and having their needs addressed by:

Local Businesses

Police

Eleven District & Borough Councils

Six healthcare trusts

Surrey County Council

Community healthcare providers

GP practices and other primary care providers

Six Clinical Commissioning Groups

Fire and Rescue Service

4,500 - 6,000 VCFS organisations

Approximately 386 schools & academies

Higher and further education establishments

Three health & care partnerships (ICSs/STP) - and their respective Integrated Care Partnerships (ICPs)

Surrey is one of the most densely populated shire counties in England, with almost one in five of the population aged 65+ and life expectancies amongst the highest in the country.

Only 8.8% of children in Surrey are from low income families, with Surrey being within the top 10 least deprived counties in England. People in Surrey on average are relatively healthy, with obesity prevalence in children at almost 7% lower than the national average. Additionally the employment rate in Surrey is again above the national average at 77.7%, with children on average succeeding academically with over 65% of children achieving 5 or more GCSEs at grades A*- C.

Although on the whole Surrey is widely perceived as a 'healthy and wealthy' county, it is not without its share of challenges. It is estimated that 10,600 5 to 15 year-olds in Surrey have a mental health disorder.

Similarly, there is considerable variation in deprivation, with over 23,000 children in Surrey living in poverty, which is linked to poor health and wellbeing outcomes for them and their parents.

Whilst there remain areas that need to be improved, the system already has a number of strategies and agreements to tackle these challenges, including the *Community Vision for Surrey in 2030* and the *Surrey Heartlands devolution agreement* which gives more local freedom to decision-making and pooling of budgets. As a result Surrey has been able to develop momentum to start working together on achieving its desired outcomes.

Surrey has the opportunity to capitalise on the assets and resources available, including the ability to work collaboratively across organisations, to address challenges and improve outcomes for the people of Surrey.

A more detailed understanding of Surrey's population and the opportunity is detailed in appendix two (Priority Area Scorecards).

Understanding the health and wellbeing of our population

We have used the life phases of *Start Well*, *Live Well*, and *Age Well* as a framework for understanding the current health and wellbeing of our population. The *Surrey Joint Strategic Needs Assessment* has provided a comprehensive source of information to inform our strategy.

This analysis has helped us define the opportunity for generational and sustainable long-term change through:

- Improved health and wellbeing outcomes for the population;
- A reduction in health and care activity; and
- Reducing the financial burden on the public sector.

We intend to use this plan to drive an ambitious push for change, rather than simply reacting to short-term challenges. Surrey has an abundance of assets and resources we can capitalise on to think and work differently.

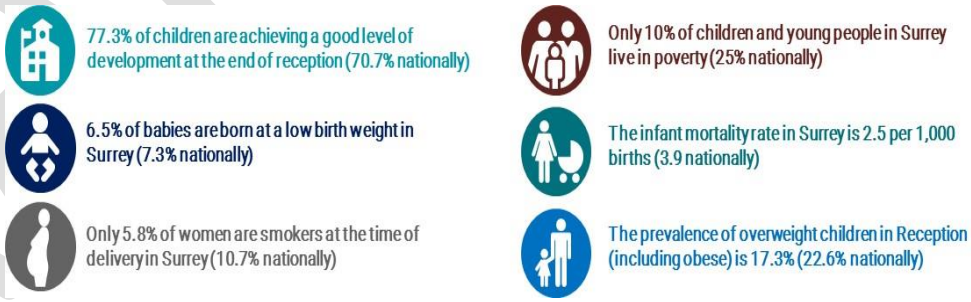
This strategy outlines our key priority areas, the evidence base to support this and a plan of what needs to change across partners in the system to deliver this change.

Starting well in Surrey

There are over 70,000 children under the age of five in Surrey, out of a total population of approximately 1.1 million, with needs that vary greatly across the county.

It is widely known that the first five years of a child's life are critical to their future development. These years are therefore an important foundation for building caring, productive and healthy families and communities. Helping children get the best start in life is both good for them and good for our society.

Early years' indicators depict Surrey on the whole as performing well compared to the national average and to the region:



However, in Surrey there are also pockets of inequality, which have a significant impact on those children's outcomes - both health related and more widely. The Income Deprivation Affecting Children Index indicates that whilst overall 10% of Surrey's children are impacted by income deprivation, in the worst affected areas over 40% are affected. Where poverty exists, it is also frequently accompanied by higher incidence of poorer average health, obesity, isolation and difficulty accessing local support services.

Living well in Surrey

Most people in Surrey lead healthier lives than the average UK citizen.

However, this strong average performance often masks areas of underperformance, inequality or where additional focus is required for the future.

Areas where Surrey performs well:

- Healthy life expectancy at birth (Female): 68.1 years (63.9 nationally)
- Healthy life expectancy at birth (Male): 68.9 years (63.3 nationally)
- People reporting low life satisfaction: 3.7% (4.5% nationally)
- Unemployment: 3.4% (4.8% nationally)
- Utilisation of outdoor space for exercise/health reasons: 20.5% (17.9% nationally)
- Employment rate (aged 16-64): 79.5% (74.4% nationally)
- Income deprivation: 7.0% (14.6% nationally)
- 16-17 year olds not in education, employment or training: 4.3% (6.0% nationally)
- Excess weight in adults (aged 18+): 55.9% (61.3% nationally)
- Smoking prevalence in adults (aged 18+): 10.9% (14.9% nationally)
- GCSEs achieved: 65.6% (57.8% nationally)

Areas of inequality and underperformance:

- 22% of all adults and 13% of all children in Surrey are obese, with the rate of adult obesity increasing at an average of 18% per year since 2014 (obesity and excess weight rates are 13.5% higher in deprived wards than the average Surrey ward).
- The proportion of people in Surrey living in overcrowded homes is set to rise by 5% over the next 10 years, specifically for the population living in more deprived wards.
- Smoking rates in Surrey amongst routine manual workers are 15% higher than average Surrey rates.
- In relation to educational attainment, children who qualify for free school meals in Surrey have considerably worse performance than the average child receiving free school meals across England.
- Surrey's employment rates for adults with learning disabilities has decreased by 35% since 2011.

Ageing well in Surrey

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by over 18%. As this population cohort grows in size, Surrey can also expect an increase in the number of people with complex conditions such as dementia, chronic kidney disease and other conditions related to ageing.

A further impact of Surrey's ageing population is that by 2023 the number of carers aged 85+ will have increased by 31%, with only a total 8% increase expected in the number of carers across all ages.

Dementia is a particular issue in Surrey. Compared to the peer group average in 2016/2017, the ratio of hospital inpatients with dementia was 11% higher in Surrey. Furthermore the level of hospital emergency admissions for patients aged 65+ with dementia is also 12% higher in Surrey. The higher life expectancy in Surrey is likely to be a contributing factor. With a high predicted growth in the over 65 population, this challenge is only likely to grow, meaning a greater focus on prevention and early support.

Supporting this cohort will need to be done through a partnership approach as there is no one organisation that can do this alone.

As of 2017 18.7% of the population in Surrey was aged 65+ (18% nationally) where the range per locality is between 23% and 16.3%,

Approximately 1 in 25 people aged over 65 in Surrey lived in care homes in 2015, which is expected to increase by 60% by 2030.

It is estimated that there are approximately 22,000 people with frailty in Surrey currently, expected to increase by almost 30% by 2030.

Citizen engagement

It is critical that alongside the data we have about people's health and wellbeing, we understand and act on the feedback we get from our citizens. Citizen engagement has and will continue to form a vital role in the design and delivery of this strategy – of which there are three key phases:

Phase one: Using the feedback we have.
In developing our strategy, we have used a wide range of resident and patient feedback to inform our priorities. These include the findings from: the quarterly Surrey Residents' Survey; the Connected Care Survey; the Mental Health Survey; and the widest resident engagement exercise ever undertaken by Surrey County Council in the development of the Surrey 2030 vision. Alongside this, our stakeholder workshops involved Healthwatch Surrey and a range of service user / patient representative organisations to ensure a strong resident / patient voice, alongside the expertise of key stakeholders.

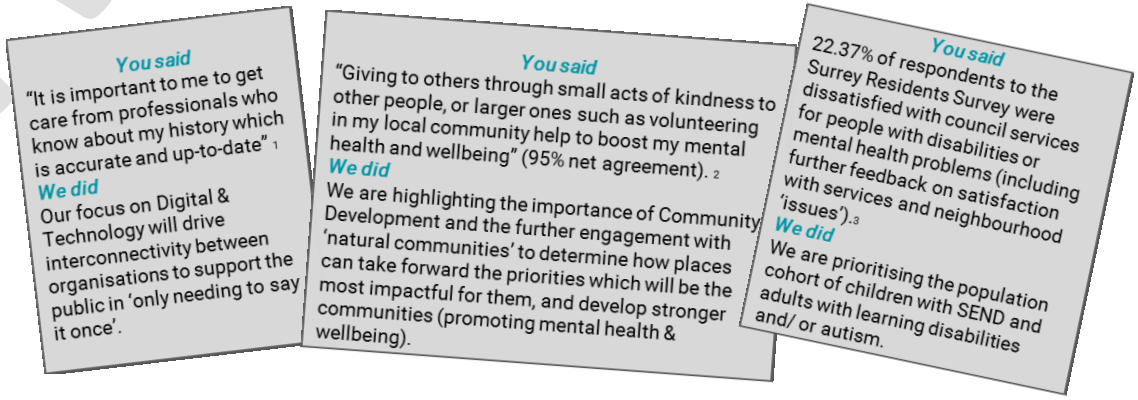
Phase two: Publishing the draft plan to test it.
Whilst we are confident that the approach we have taken to develop this draft strategy was robust – based on evidence, resident / patient views and the expertise of professionals working across the system - it was important to make this draft strategy available for people to comment on. This will help test that we've got it right and that we have translated the evidence available into a set of priorities and ambitions that are clearly understood and recognised. So we're now asking for your feedback before taking the draft strategy to the Health and Wellbeing Board for approval.

Phase three: co-design and co-production
Our strategy is ambitious – we want to secure the best health and wellbeing outcomes possible for our population. But no single organisation or group of organisations can do this without the active involvement of citizens – i.e. residents, patients and carers.

Partners across Surrey are committed to working with residents to co-design and co-produce the solutions we need to achieve the outcomes described in this strategy. We know this will require partner organisations to work differently and to redefine how citizens and our organisations work together.

We're embedding this as one of the key enabling programmes ('system capabilities') described later in this document to help ensure we maintain our focus on citizen engagement and involvement.

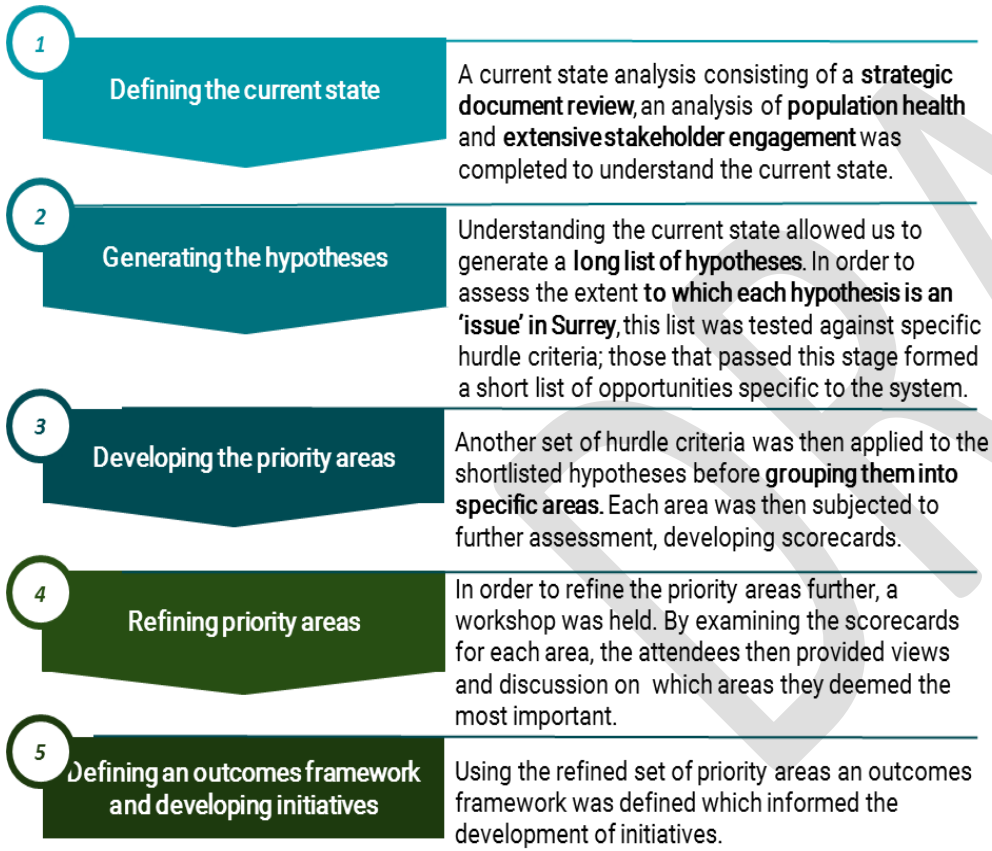
We've already put the findings from the feedback citizens have given us to good used, as described in 'phase one' above. These rich sources of insight have been used to shape our priorities – for example:



PRIORITIES FOR SURREY

Approach

We used an evidence based approach in developing our strategy, so that we focus on Surrey's greatest challenges and, where appropriate, target the groups of the population that need additional help to achieve their target outcomes. This approach is summarised below and further details can be found in Appendix four (methodology and approach).



Priority areas and population groups

Surrey will focus on three interconnected priorities: ***fulfilling potential***, ***leading healthy lives*** and ***having good emotional wellbeing***.

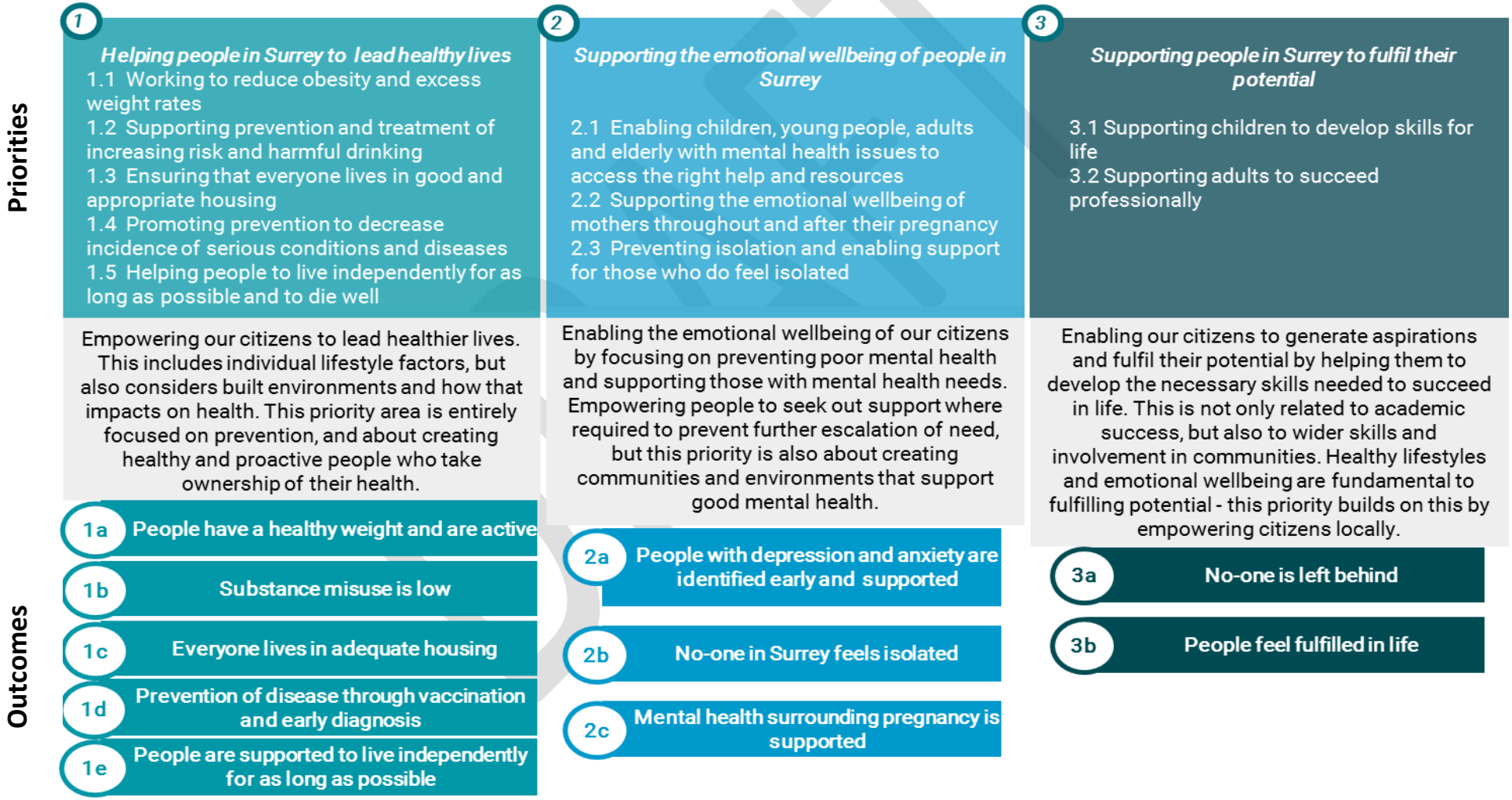
To avoid any groups of the population being left behind, Surrey will focus on tackling these priorities across the entire population, as well as within some specific groups of people which are often overlooked or most at risk.

These priorities and target groups – described in more detail over the next two pages - have been identified based on extensive data and benchmarking analysis as well as stakeholder engagement across the county. They focus on prevention in its earliest form, and on providing the right 'place' for the population to thrive and reach their full potential.

The target outcomes for each priority focus on areas where Surrey has been underperforming, or where performance has been deteriorating. This allows for the plan to take a targeted approach in improving outcomes for those who would benefit the most whilst also creating clarity for the system on the direction of travel and long-term vision.

Surrey's priorities and outcomes

Surrey's selected priorities are described below - these have been categorised for pragmatism, but we recognise the fundamental importance of mental health and wellbeing as connected parts of living health lives; and the role of good physical and mental health in enabling people to fulfil their potential. Outcomes have been identified for each priority - these are the goals and overall targets the system will work towards for our population. Specific metrics for measuring these outcomes per cohort have been identified to allow a clearer understanding of progress and measurement of the target outcomes. The detailed methodology and outcomes matrix is included in Appendix Four (methodology and approach).



Surrey's priority population groups

The aim of this strategy is to address outcomes for the whole of Surrey - driving change across the population at pace and scale. However, it also recognises that specific groups of people suffer disproportionate inequalities in outcomes, and therefore may require specific and targeted support/resource to bring their outcomes to be on par with the wider population. We have identified these priority groups below.

A General Population

This refers to the entire population of Surrey. This plan aims to address the wider determinants of health and wellbeing for all of Surrey, with a strong focus on prevention.

B Children with SEND and Adults with Learning Disabilities and/or Autism

Children with special education needs and disabilities, and adults with Learning Disabilities and/or Autism. The focus is on improving the outcomes for this cohort and on providing opportunities for them to achieve their potential.

C Young and Adult Carers in Surrey

All young and adult carers in Surrey. The focus is on supporting this population cohort and creating opportunities for this cohort to be part of their local community and as a result avoid feeling isolated.

D People who need support to live with illness, live independently, or to die well

Those people living with illness, including long term conditions, multimorbidities, people who require support to live independently, and people who require support to die well. Our focus is to promote self management where possible, independence, and use of community assets and resources.

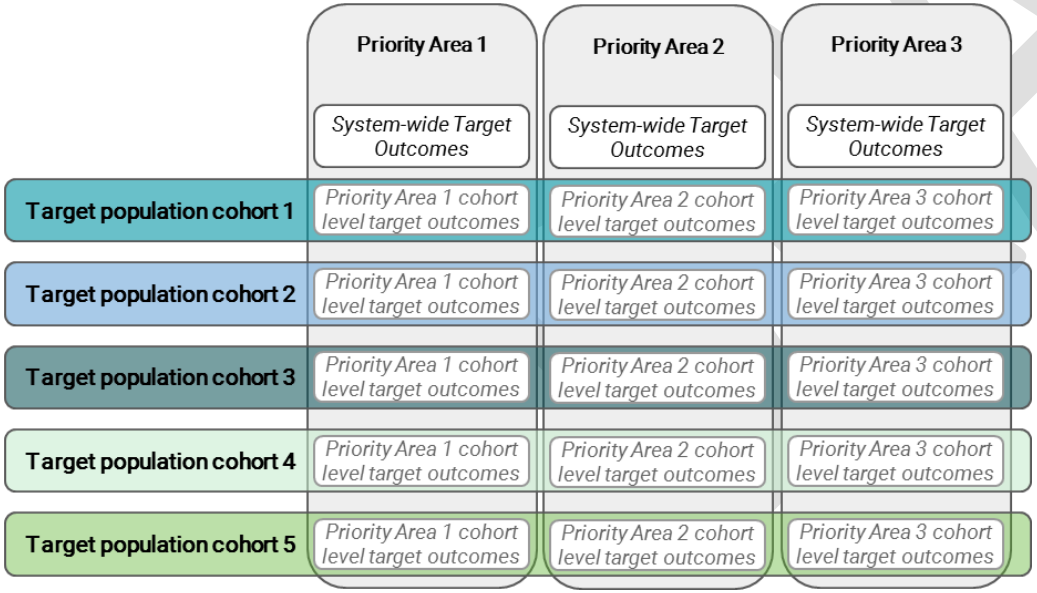
E Deprived or vulnerable people

Those people living in deprivation, or those who are vulnerable across Surrey. This includes children in care and care leavers. The aim is to place a focus on this cohort which based on indicators has been left behind in the past, and improve their health outcomes.

Measuring and tracking success and delivering ambition at a population group level

Fulfilling potential, leading healthy lives, and having good emotional wellbeing have different meanings and implications depending on the environment and conditions for each individual. So whilst the system-wide priorities remain the same for each population group, the definition of success has been adapted to each target population group. This is to avoid the overall positive outcomes for the wider population masking the existing areas for improvement and poor outcomes for specific groups.

Identifying how the system-wide outcomes relate to each population group helps us measure and track success more clearly. In addition, this puts a specific focus on those groups who may have been left behind in the past, or may not have had their outcomes measured or addressed in a way that delivers the greatest impact.



Our priority groups in more detail

This section describes each of our priority population groups in a bit more detail – for each one you'll find:

- A definition of the population group
- A description of the difference we're trying to make through some key measures of success – this includes 10 year outcome targets and the financial and activity impact
- A description of example initiatives or programmes we have identified – these are not the explicit initiatives that will be implemented but provide a view of how outcomes may be achieved and how we can capture learning from best practice elsewhere to deliver improved outcomes
- A description of how we will need to work together differently as partners to achieve our ambitions ('building capabilities').

Appendix Four describes how we have developed the measures and targets for each of these population groups. The use of further measures identified through recent engagement activity is also being explored – a summary of these additional measures is captured in Appendix Six.

Population group one - *general population*

Definition:

General population - this refers to the entire population of Surrey. This plan aims to address the wider determinants of health and wellbeing for all of Surrey, with a strong focus on prevention.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance		Target Performance	10 Year Target Outcomes Impact: Financial Impact
People feel fulfilled in life	Reported low life satisfaction	3.7%		3.2%	To be added when the finance / activity modelling has been completed
People have a healthy weight and are active	Obesity admission rate per 100,000 population	East Surrey CCG	499	236	
		G&W CCG	551	510	
		North West Surrey CCG	473	499	
		Surrey Heath CCG	876	682	
		Surrey Downs CCG	382	220	
		NEH&F CCG	374	194	
Substance abuse is low	Successful completion of alcohol treatment	32.2%		51.8%	
Prevention of disease through vaccination and early diagnosis	Vaccination rates	DTaP/IPV/Hib	88.1%	98.4%	
		Pertussis	82.9%	92.9%	
		MMR	81.7%	93.6%	
		Rotavirus	89.0%	95.3%	
	Diabetes diagnosis rates	69.4%		79.1%	
	Bowel cancer screening coverage	60.6%		65.3%	
People with depression and anxiety are supported	Depression prevalence	East Surrey CCG	7.0%	6.2%	
		G&W CCG	7.5%	6.2%	
		North West Surrey CCG	6.2%	6.5%	
		Surrey Heath CCG	6.3%	5.3%	
		Surrey Downs CCG	6.8%	6.2%	
		NEH&F CCG	8.6%	6.5%	
	Anxiety prevalence	19.5%		14.1%	

Outcome metrics 'Mental health surrounding pregnancy is supported' and 'No-one in Surrey feels isolated' have not been modelled due to the availability of data.

The general population - examples of supporting initiatives

1. Use of community assets and local organisations to promote healthy lifestyles across Surrey

- Improving the wellbeing of people across Surrey through **local-level initiatives**, including:
  - Improving physical activity access through utilising local assets (parks, greenspaces);
  - Improving access to healthy food through farm stands and corner stores;
  - Promoting neighbourhood safety by addressing pedestrian safety and crime challenges; and
  - Coordinated school health programmes.
- Communities with specific challenges are selected, and based on the available local assets, a **coalition of local organisational leaders** is put together to **oversee the programme** and multiple initiatives (multi-organisational).
- Example initiatives: farm stands set up at local schools and joint-use agreements set up for school playgrounds and parks in schools to promote physical activity and healthy eating promotion.
- Where this has been implemented a **30% reduction in perception of barriers to physical activity** was realised, where this correlated with an increased usage of neighbourhood assets and **improvements in physical activity utilisation behaviours by 20%.**
- Furthermore a **20% increase in awareness of barriers to healthy food access was realised**, with an increased utilisation of local good retail outlets.

2. Mental health first aid training of the Surrey-wide workforce

- Whilst to date there are some organisations across Surrey which provide basic mental health first aid training to their workforce, this would be the opportunity to train employees **across all organisations in Surrey** to be mental health first aiders. This would include both public sector organisations a part of the Surrey-wide partnership, but also **further organisations and businesses** (e.g. local businesses).
- Where mental health first aid training has been implemented in their workplace;
  - 91% of employees surveyed have said there had been an **increased understanding of mental health issues**;
  - 88% reported an **increase in confidence around mental health issues**;
  - 87% said **more mental health conversations were happening at work** as a result of the training;
  - 83% noticed an **improvement in procedures for signposting to further support**; and
  - 59% reported an **increase in help-seeking behaviour.**
- This initiative would focus on a Surrey-wide, partnership driven, promotion of mental health first aid training in partnership and wider organisations.

Sources: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5874305/, http://www.ssehsactive.org.uk/userfiles/Documents/eonomiccosts.pdf, https://www.thelancet.com/action/showPdf?pii=S0140-6736%2812%2960766-1, https://mhfaengland.org/mhfa-centre/news/mentor-study-research/, https://mhfaengland.org/individuals/adult/2-day/

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population	High	High	Medium
Deprived	High	High	Medium
People with SEND and LD/Autism	Medium	Medium	Low
Young and Adults Carers	Medium	Medium	Low
Living with illness & ill health	Medium	Medium	Low

Potential Finance and Activity Impact of initiatives*

Promoting Healthy Lifestyles	Mental Health First Aid
£	£
X	X

* To be added when the finance / activity modelling has been completed.

The general population - building capabilities

In order to implement these types of initiatives successfully, we will need to engage with all the necessary partners from within health and social care and beyond, and put in place the governance and infrastructure to enable the successful delivery of the initiatives. To achieve the target outcomes for the general population we will build the following types of capabilities:

Community development

- Progressing forward with the 'Surrey deals' being developed by Surrey County Council to agree clear 'pledges' with the community.
- Agree the communications and engagement strategy to be translated at the local level (district & borough) to co-develop initiatives with local people.
- Agree how that strategy interacts with the local workforce to create a two-way loop for feedback.

Clear governance

- Agreement on Health and Wellbeing Board responsibilities in relation to all of the outcome targets.
- Communication to the general public of the outcome targets and governance to be used to create accountability.

Estates

- Public sector estates strategy that encourages community based, multi-organisational provision to focus on building stronger asset-based communities.

Workforce and culture

- Development of a multi-organisational workforce deal to promote public sector employment in Surrey and to grow the required capabilities.
- Define the required culture, value and behaviours required by the workforce, including system leadership to achieve the target outcomes.

Programme management

- Define and embed programme and project management support capable of managing multi-agency projects across the general population.
- Create a central view of existing local and system-wide initiatives across Surrey to undertake portfolio management activities to identify areas of duplication and overlap.

Digital and technology

- Scoping of existing digital and technological capabilities and maturity across key system partners to identify need or gaps in capability to be able to effectively work collaboratively.
- Development of system interoperability to enable data sharing across organisations for early identification and support where appropriate.
- Development of system network, enabled digitally, to enable clearer signposting by partners.

Intelligence

- Refining of the information captured and metrics measured by the system (e.g. measuring indicators such as fulfillment or happiness across Surrey).
- Utilisation of geographic data across organisations to better equip local systems to develop targeted and universal initiatives for their populations.

Devolution / alignment of incentives

- Funding agreements determined based on priority areas and prevention.
- Ability to alter statutory requirements of services in line with the target outcomes.
- Ability to pool budgets and subsequently jointly fund initiatives and services.

Population group two – *children with special education needs and disabilities (SEND) and adults with learning disabilities and / or autism*

Definition:

Children with special education needs and disabilities, and adults with learning disabilities and/or autism - the focus is on improving outcomes for this group and on providing opportunities for them to achieve their potential.

The difference we're aiming to make:

				10 Year Target Outcomes Impact
Outcomes	**Metrics for Measurement**	**Current Performance**	**Target Performance**	**Financial Impact**
Adults with LDs/Autism feel fulfilled in life	Adults with LDs in employment	10.0%	16.4%	Data unavailable
People with LDs live in adequate housing with the adequate support	Rates of people with LDs living in settled accommodation	67.7%	82.4%	

Children with SEND and adults with learning disabilities and / or autism - examples of supporting initiatives

1. Implementation of community interest groups led by adults with learning disabilities

- Community coordinators, established by the partnership, **enable people with learning disabilities to set up and run interest groups in their local areas.**
- People are supported to shape their ideas, identify locations, invite group members and **make groups a reality in their local communities.**
- The established groups **draw on community assets** to facilitate activities (e.g. through equipment donation from local businesses, use of existing under utilised estates or co-locating groups with other activities to facilitate greater community join-up).
- Where this has been implemented nationally it has had a **transformative impact of the wellbeing** of both group leaders and group members.
- Participants have since gone on to **achieve qualifications, further volunteering activities or employment.**
- Additionally it has contributed to the **changing of perceptions** of people with learning disabilities and/or autism, and has developed new networks across VDFS and local businesses.
- In the context of Surrey the partnership would be able to use its respective data and information, or if possible join up this information, to better **understand individuals with learning disabilities who require support and in which communities.**

2. Shared Lives model for those with learning disabilities

- **Individuals with learning disabilities either live, or regularly visit households in the community,** in order to improve wellbeing and sense of community.
- This would require the household carers to be **appropriately trained and approved,** as well as those provided with payment.
- Where this has been implemented nationally this has improved the wellbeing for people with learning disabilities through;
  - **Sense of permanency;**
  - **Security stability**; and
  - **Consistency of residing with one household for an extended period of time** (often years).
- Furthermore a **higher quality of care** was experienced (on average) with 92% rated as good / outstanding and 0% rated as inadequate.
- An average £26,000 reduction in cost of care per person with learning disabilities compared to existing packages was experienced.
- In addition to the benefits gained for the individual, this initiative focuses on building stronger communities that support each other, which includes those currently providing care for those with learning disabilities.

Sources: https://www.communitycatalysts.co.uk/wp-content/uploads/2018/06/The-Do-Your-Thing-project-published-report-November-2017.pdf, https://sharedlivesplus.org.uk/images/300718_SLP_England_LR.pdf, https://www.socialfinance.org.uk/sites/default/files/publications/sf_shared_lives_final.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population			
Deprived			
People with SEND and LD	High	High	High
Young and Adults Carers	Low	Low	Low
Living with illness & ill health			

Potential Finance and Activity Impact of initiatives*

Community interest groups	Shared Lives
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Children with SEND and adults with learning disabilities and / or autism - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For children with special education needs and disabilities, and adults with learning disabilities and/or autism we will build the following types of capabilities:

Community development

- Developing a clear network of the existing VCFS and system-partners working with children with SEND and adults with LDs across Surrey. This allows for a stronger gathering of existing insights of cohort.
- Promotion of community level engagement to co-develop initiatives based on local needs of children with SEND and adults with LDs.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts' needs.

Estates

- Mapping exercise of existing estates utilised to provide care and support for children with SEND and adults with LDs, to identify opportunities for co-location and more focused community based provision.
- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access.

Workforce and culture

- Development of workforce 'passport' to allow those who work with children with SEND and adults with LDs to move between organisations to share knowledge, experience and practice.
- Workforce development to train all staff to better recognise and provide for the needs of this cohort, and feel confident in an appropriate response.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects for children with SEND and adults with LDs. This provides an opportunity to understand where there may be duplication in the system as well as existing gaps resulting in a fragmented offer for children and adults.

Digital and technology

- Understand the existing digital maturity of system partners in providing care and support to this population cohort. This allows for understanding where there are gaps in allowing for system interoperability but also where there are opportunities to use technology differently in service provision and in enabling people to live independently.
- Development of system-wide place strategy for utilising digital and technology in the provision of care for this population cohort.
- Development of system network, enabled digitally, to enable clearer signposting by partners.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort.

Devolution / alignment of incentives

- Ability to alter statutory requirements of services for those with Learning Disabilities and / or Autism in line with the target outcomes and wider determinants.
- Ability to pool budgets and subsequently jointly fund initiatives and services for those with Learning Disabilities and / or Autism.
- Payment reform of services for those with Learning Disabilities and / or Autism to align incentives across the system.

Population group three – *young and adult carers*

Definition:

All young and adult carers in Surrey. The focus is to develop more support for carers and create opportunities for them to feel part of their local community to avoid feeling isolated.

The difference we're aiming to make:

				10 Year Target Outcomes Impact
Outcomes	**Metrics for Measurement**	**Current Performance**	**Target Performance**	**Financial Impact**
Carers are supported to lead balanced and fulfilling lives	Carer-reported quality of life (out of 12)	7.9	8.4	To be added when the finance / activity modelling has been completed

Outcome metrics 'Rates of unpaid carers' and 'No-one in Surrey feels isolated' have not been modelled due to the availability of data.

Young and adult carers - examples of supporting initiatives

1. Identification and support of young carers through community pharmacies

- An initiative to **partner with pharmacies** across Surrey to improve the early identification of young carers and their families, and supporting pharmacies to engage with carers to provide the appropriate support.
- This would require:
  - **Training pharmacy staff on issues affecting young carers**;
  - **Carers' champions in pharmacies**;
  - **Confidential referral process**;
  - **Support information in pharmacies**; and
  - **Shared learning**.
- The benefit of this initiative is that young carers and their families are **identified early** and in their local communities, leading to timely assessment and / or engagement with appropriate support services.
- Furthermore through early identification, young carers and their families receive **early support and inappropriate caring roles are prevented or removed at an early stage.**
- As a result young carers and their families are able to make **better use of pharmacy services**, and there is an improved understanding of the processes in place for dispensing medicines to young carers.
- The use of pharmacies is an **ideal route to engage meaningfully with young carers** as it is in their local communities and at locations they already frequent.
- *It should be noted this work is currently underway in Surrey.*

2. Carers health and wellbeing programme

- Currently there are a number of VCFS organisations across Surrey providing care and support for both young and adult carers. This initiative would be focused on **a partnership approach to a carers health and wellbeing programme, pulling on partnership working beyond what currently exists across Surrey.**
- This initiative is a focused programme which **promotes the encouragement of carers to take ownership of their physical and emotional health** through;
  - **One-to-one support** by a multi-skilled individual who can effectively coordinate needs across multiple organisations; and
  - **Awareness raising** across the partnership and with local businesses.
- The goal of this initiative, and what has been realised elsewhere through similar programmes, **is an increase in access to social activities, increase in confidence and reduced stress / anxiety of carers.**
- A number of health and wellbeing initiatives related to Carers are already embedded through existing workstreams across Surrey.

Sources: https://professionals.carers.org/sites/default/files/the_young_carers_pharmacy_project_evaluation.pdf, https://www.carersleeds.org.uk/wp-content/uploads/2016/02/Carers-Leeds-report-FINAL-.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfill Potential
General Population			
Deprived			
People with SEND and LD			
Young and Adults Carers	High	High	High
Living with illness & ill health	Low	Low	Low

Potential Finance and Activity Impact of initiatives*

Young carers and pharmacies	Carers Health and Wellbeing
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Young and adult carers - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. To achieve the target outcomes for young and adult carers we will build the following types of capabilities:

Community development

- Requirement to work with the existing VCFS organisations that directly support carers (for example Action for Carers) to create clarity on this cohort and their needs. This cohort is often difficult to identify and therefore to support, and therefore using local knowledge will be integral.
- Promotion of community level engagement to co-develop initiatives locally based on this knowledge, for example with local community navigators.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- There is no one clear organisation accountable for the outcomes of this cohort, and therefore clear multi-organisational accountability and governance must be developed and communicated (e.g. Surrey Young Carers Strategy Group and Young Carers forum which oversees the implementation of the joint multi-agency Surrey young carers strategy).

Estates

- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access, use and self management of needs.
- This strategy can utilise existing estates to co-locate provision or information for carers alongside those services they most often require (e.g. mental health support, community based activities to reduce social isolation).

Workforce and culture

- Workforce development to train all staff to better identify and understand carers and be able to signpost effectively to meet the needs for this cohort.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects for carers, possibility building specifically on the existing capability within the VCFS.
- It is likely carers may be an aspect of wider reaching multi-agency projects, and therefore utilise programme management to identify the interdependencies proactively and effectively.

Digital and technology

- Development of a system network, enabled digitally, to support clearer signposting for carers and access to useful information. This can include the use of existing digital platforms which exist across Surrey which are to be joined up between system partners and iterated on a local level.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort (e.g. support for implementing housing initiatives to contribute to better outcomes for young adult carers).
- This includes the identification of additional metrics to better understand and predict outcomes for carers (e.g. Carers alert thermometer for young carers aged 11-18, Zarit Carer Burden Scale)

Devolution / alignment of incentives

- Additional benefits of devolution to be explored.

Population group four – *those who require support to live with illness, live independently, or to die well*

Definition:

Those people living with illness, including long term conditions, those with multiple conditions, people who require support to live independently, and people who require support to die well. Our focus is to promote self-management wherever possible, greater independence and use of community assets and resources.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance	Target Performance	10 Year Target Outcomes Impact: Financial Impact
People live in appropriate housing with easy access to the services they need	Excess winter death index	12.4	8.7	To be added when the finance / activity modelling has been completed
	Rates of supported working age adults whose accommodation status is severely unsatisfactory	15%	14%	
People live independently at home for as long as possible	Rates of older people still at home 91 days after discharge from hospital	69.9%	91.2%	
	Emergency admissions rates of those with dementia per 100,000 population	3,272	2,496	
People in Surrey die well	Rates of deaths in usual place of residence in those aged 65+	49.4%	55.2%	

Outcome metrics 'No-one in Surrey feels isolated' has not been modelled due to the availability of data.

Those who require support to live with illness, live independently, or to die well - examples of supporting initiatives

1a. 'Virtual Hospital'

- An initiative to support people to stay out of hospital and reduce their lengths of stay through **enabling patients to receive consultant-led medical care in their homes.**
- This would be as an **alternative to waiting in a hospital bed in advance of a next procedure**, and with the goal of improving the wellbeing of patients by allowing them to be able to recover in their home.
- Where this has been implemented elsewhere 87% of appropriately referred patients were able to stay at home, **saving over 220 bed days**.
- There is the opportunity to extend this initiative further to involve more system partners, for example **community based programmes to promote health and independence following medical treatment** enabled by joining up of information between organisations.

1b. Enhanced health in care homes - medication management

- Supporting care homes to have an **effective 'care home medicines policy'** which aims to avoid unnecessary arm, reduce medication errors, and optimise the choice and use of medicines with care home residents.
- This would be a joint initiative between health and care to improve medicines management leading to better health and wellbeing for residents.

2. Improving the mental health and wellbeing of people living with long term conditions

- Innovative forms of liaison psychiatry have demonstrated that **providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals.**
- This initiative would therefore drive **collaborative care arrangements between primary care and mental health specialists** to improve outcomes with no or limited additional net costs.
- CCGs would prioritise **integrating mental and physical health care** more closely as a key part of the strategy to improve quality and productivity of health care.
- An example of this could include the inclusion of a psychological component in a breathlessness clinic for COPD in an acute provider.

3. Multi-generational Care Homes and 'Rent a Granny' Schemes

- Initiatives that focus on integrating the ageing population into their community, providing opportunities for fulfillment and thinking differently about what living with LTCs and dying well means are able to be implemented across Surrey **at a local level**.
- 'Rent a Granny' as an example, already active in parts of Surrey, focuses on identifying members of the ageing population and families in the community who would **mutually benefit from social interaction.**

Sources: https://www.kingsfund.org.uk/blog/2018/10/better-value-and-better-nights-sleep, https://www.thetelegraphandargus.co.uk/news/15317496.virtual-elderly-care-ward-wins-national-award/, https://www.kingsfund.org.uk/sites/default/files/2017-11/Alison_and_Maj.pdf, https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640714/Commissioning_effective_mental_health_prevention_report.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population			
Deprived			
People with SEND and LD			
Young and Adults Carers			
Living with illness & ill health	High	High	Medium

*Potential Finance and Activity Impact of initiatives**

Virtual hospital & meds management	Collaborative mental health
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Those who require support to live with illness, live independently, or to die well - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For those who require support to live with illness, live independently, or to die well we will build the following types of capabilities:

Community development

- Community engagement strategy that focuses on building communities and identifying local assets to support those with ill health and those who require support to live independently.
- Identification of existing community assets to engage further with people and communities to understand their needs and gaps in initiatives.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts needs.

Estates

- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access. This will include co-location of services accessed by this cohort of the population to reduce unnecessary travel and to promote access and self-management of needs where appropriate.

Workforce and culture

- Development of workforce 'passport' to allow those who work with this population cohort to move between organisations to share knowledge, experience and practice.
- Workforce development to create clarity across all system partners of how best to support this population of the cohort in the long term.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects individuals living with illness, including VCFS, health, care and wider partners. This provides an opportunity to understand where there may be duplication in the system as well as existing gaps.
- The same can be done for those who require support to live independently though this will require stronger link in to local communities.

Digital and technology

- Development of system-wide place strategy for utilising digital and technology in the provision of care for this population cohort.
- Development of system network, enabled digitally, to support clearer signposting to organisations that can provide for locally based community provision of support.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort.
- Develop system interoperability to share information on this population cohort between organisations to provide more targeted support.

Devolution / alignment of incentives

- Ability to pool budgets and subsequently jointly fund initiatives and services for those requiring support to live independently.

Population group five – *the deprived or vulnerable population*

Definition:

Those people living in deprivation, or those who are vulnerable across Surrey. This includes children in care and care leavers. The aim is to focus on those where indicators suggest they may have been left behind in the past and improve their health outcomes.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance	Target Performance	10 Year Target Outcomes Impact: Financial Impact
Children and Young People who are deprived or vulnerable succeed academically	*School readiness at reception for children who receive free school meals*	31.0%	39.2%	To be added when the finance / activity modelling has been completed
	GCSEs achieved (5A-C) for children with free school meal status*	40.0%	42.5%	
	GCSEs achieved (5A-C) for children in care*	17.2%	23.9%	
People in deprived areas feel fulfilled in their employment	*NEET rate*	4.3%	3.3%	
	Unemployment rate	2.4%	1.8%	
People in deprived areas have a healthy weight and are active	Obesity rates	25.4%	22.0%	
Substance abuse in deprived areas is low	Excessive alcohol consumption rates	19.0%	18.0%	
	Smoking rates	26.0%	11.0%	
People live in adequate housing with access to services	Overcrowded housing	3.4%	2.1%	

Outcome metrics 'People with depression and anxiety are supported', 'No-one in Surrey feels isolated' and homelessness rates have not been modelled due to the availability of data.

The deprived or vulnerable population - examples of supporting initiatives

1. Targeted support for the vulnerable or deprived children and young people in Surrey

- The joint-establishment of 'link workers' to be based in local schools, nurseries and children's centres to **identify the children and young people who would benefit from a range of new opportunities in school, provided by community partners.**
- Partners are those local VCFS who provide a wide range of services (e.g. drug and alcohol abuse, sexual health and financial literacy) but can also include community based health and care providers.
- Where implemented elsewhere the following benefits were experienced;
  - **80% of children improved attainment, wellbeing and / or attendance in school after one year of establishment**; and
  - 85% engaged with the support to a high level.
- A link worker would be able to understand at a much more granular level **the root causes behind existing poor outcomes for children in Surrey living in deprivation or who are vulnerable,** and therefore be proactive in coordinating the necessary support to tackle the need.
- There is also the opportunity to consider how the **entire family of those children and young people** living in deprivation or who are vulnerable becomes part of the conversation, for example a link worker signposting to the effective services.

2a. Health and Housing MoU

- The establishment of a **strategic alliance between health and housing providers and commissioners** to collectively improve health outcomes which are a result of poor housing conditions.
- Through the acknowledgment of the profound impact housing has on health outcomes, a place-based approach can be developed between health and housing beginning with a clear MoU **aligning leadership across health and housing towards common goals** of improving the health and outcomes of the population living in deprivation.

2b. Housing First rollout across Surrey

- Implementation of a model of housing for the homeless whereby people are **provided with permanent housing and support to stay in this housing for a longer period of time**, reducing the need and cost of supported housing.
- The desired impact is **increasing the stability of housing for homeless people** resulting in improved health and wellbeing outcomes. Increasing stability is enabled by the targeted support from system-wide partners (e.g health support including mental health support, social care support, employment support etc.) which is coordinated by core owners of the programme.

Sources: http://westlondonzone.org/what-we-do/, http://westlondonzone.org/wp-content/uploads/2016/10/Executive-Summary-of-WLZ-Implementation-Study-1.pdf, file:///C:/Users/942858/Downloads/Nottinghamshire%20MoU.pdf, file:///C:/Users/942858/Downloads/Nottingham%20homes%20MoU.pdf, https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/housing-models-and-access/housing-first-feasibility-study-for-liverpool-city-region-2017/

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfill Potential
General Population			
Deprived	Medium	High	High
People with SEND and LD			
Young and Adults Carers			
Living with illness & ill health			

*Potential Finance and Activity Impact of initiatives**

'Link Workers'	Housing First
£	£
X	X

* To be added when the finance / activity modelling has been completed.

The deprived or vulnerable population - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For this group, the deprived or vulnerable population, we will build the following types of capabilities:

Community development

- Strong community development and support in those areas with higher deprived or vulnerable populations.
- Clearer understanding of networks and assets available to support this population cohort, and co-development of initiatives with those networks.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts needs.

Estates

- Affordable housing strategy that redirects public sector estates resources to appropriate housing for this cohort.
- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access.

Workforce and culture

- Multi-agency case lead agreement that allows the appropriate agency to take the lead role or make required decision.
- Workforce develop to train all staff to recognise signs of vulnerability and feel confident in an appropriate response.

Programme management

- Embedded programme and project management support capable of managing cross-agency projects across the system for this cohort.
- Portfolio management evaluation of existing initiatives from across the system to understand areas of duplication and opportunities to scale up initiatives across a wider geography.

Digital and technology

- System interoperability which supports data sharing to better understand the breadth of needs of this cohort.
- Easy to access digital channels that make finding and accessing support simple and inviting.

Intelligence

- Strong data sharing between organisations and sectors to support a strong single view of individuals/families.
- Intelligent analytics to support accurate targeting of individuals and families who have higher risk factors.

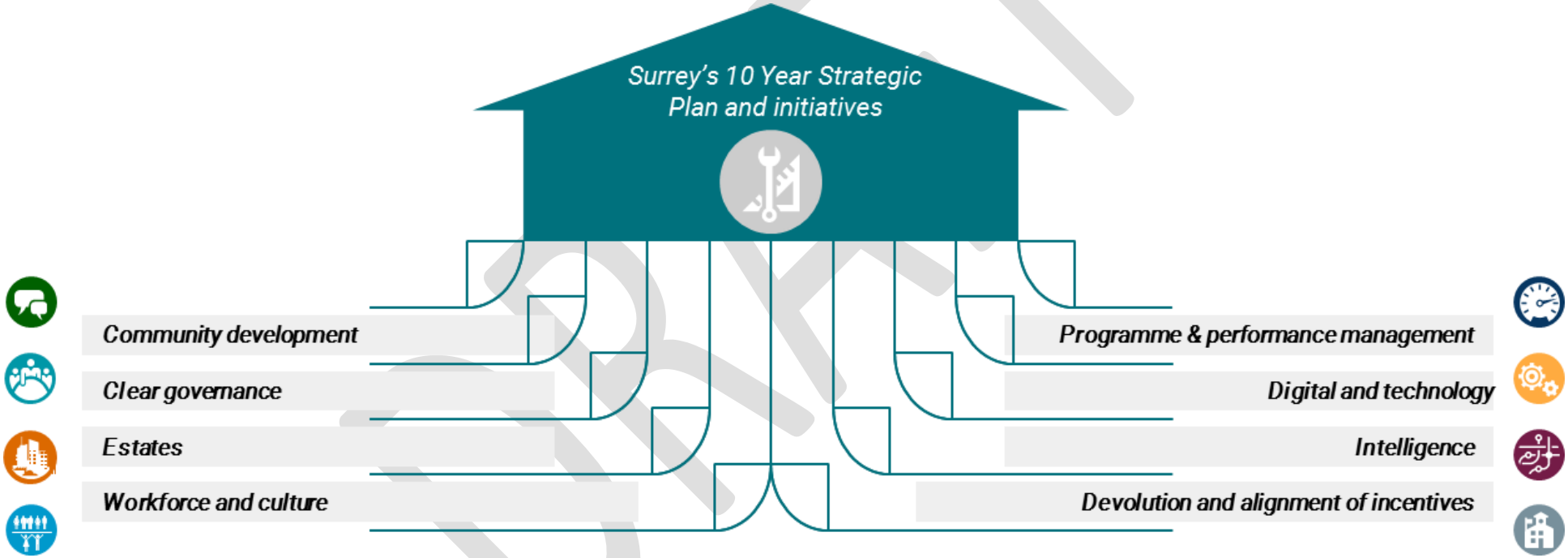
Devolution / alignment of incentives

- Ability to pool budgets and subsequently jointly fund initiatives and services for those with vulnerabilities or living in deprivation.

SYSTEM CAPABILITIES

Our target outcomes over the next 10 years give us a clear vision of what we want to achieve for our citizens and organisations in Surrey. It's also clear we need to work together in a different way and develop new capabilities if we are to meet these targets. Breaking down the barriers that might be preventing collaboration across the different parts of the Surrey system will be critical for success, and to driving real system change.

In addition to the specific capabilities we've highlight for each of the groups above, the diagram below describes the system-wide capabilities we are committed to developing and embedding. We recognise this will include some challenging decisions which must be taken by the partnership, through open and honest conversation, to allow the best outcomes to be achieved.



As we engaged partners to develop this plan, we identified a number of barriers that need to be addressed but also the desire to focus on building the necessary capabilities, particularly in digital and workforce to overcome these. That feedback has informed a number of areas that we will take forward. The next section of this strategy summarises these, with further detail included in Appendix Seven.

Community development

The co-development of communities is integral to delivering a 10 year plan across Surrey. We are committed to building clear channels for engaging local communities and residents and to support community development. Citizens require communication channels that are easy to access and use, with clear and consistent messages from Surrey partners. This needs to be a two-way dialogue between partners and citizens, but also within and between partners. This will support system decisions which are relevant and responsive to the needs of the population.

Areas of focus:

We will work to establish two-way feedback mechanisms between our organisations and local people, but also within organisations so information is more clearly communicated and responded to. This includes joining up existing community development and engagement activities (for example the existing work on Stronger Communities) to create a more consistent approach and decrease duplication.

Clear governance

We are putting in place decision-making that is simple, collaborative and clear, whilst being representative of all partners in Surrey. A refined governance process will hold the leadership across Surrey to account for delivering this plan and its outcomes. It will also replace current multiple and often overlapping meetings with a single decision-making forum. Challenges and priorities will be discussed and viewed holistically. Partners will be clear on the approval route for multi-partner decisions, with joint leadership for the strategic plan.

Areas of focus:

Aligning the focus and decision-making across the Surrey-wide system, which will include giving back time to senior leaders who attend multiple partnership meetings with duplicated remit and authority. This will include a detailed mapping of existing decision-making responsibilities to redefine a clearer and streamlined model, with clear accountabilities and terms of reference. This should be linked to the system architecture and assurance work currently ongoing within the Surrey Heartlands Integrated Care System. Ultimately the Health & Wellbeing Board will be responsible for the delivery of this 10 year plan, and therefore this framework will need to link to the membership and responsibilities of this board. It will also need to remain conscious of the various levels of governance that sit below the Health & Wellbeing Board, such as local Health and Wellbeing Boards across the Districts and Boroughs.

Estates

We will establish one consistent estates and assets approach across Surrey which focuses on:

- using a one-Surrey estates ethos to consolidate collective estates across the patch;
- multi-use, accessible, community based estates for operational uses; and
- delivering sustainable housing, supported accommodation and income-driving solutions across the county.

All partners are signed-up to a unified approach, and the appropriate decision-making powers are given to the relevant group charged with driving this through for Surrey.

Areas of focus:

Bringing together all the estates and assets transformation work currently ongoing across Surrey beneath one system-wide umbrella; Surrey County Council has already begun to combine their estates workstream with Surrey Heartlands' Estates programme. An exercise to map all estates across all partners in Surrey will be needed to understand the baseline position - Surrey County Council has already started some of this work with the Districts and Boroughs. This programme of work can then drive co-development of a single Estates and Assets Strategy for Surrey with all partners. Critically, this work will need to involve all key decision-makers (e.g. NHS Property Services at a national level; Districts and Boroughs etc).

Workforce and culture

Surrey requires a modern and radical workforce approach that will create and develop a future workforce equipped to manage the demands of the future. It will also need to work collaboratively to deliver the priorities set out in this plan. This requires a strong approach across all partners that develops the right culture, values, behaviours, skills, training, and leadership. Other areas such as adequate housing and transport for local workers also needs to be considered.

Areas of focus:

To move towards a joined up and multi-skilled 'Surrey workforce' for the public sector which is able to work collaboratively regardless of the specific employer. This could be enabled by joining up the existing workforce, and/or creating a 'workforce passport' which allows employees to share knowledge and experiences across the system. A Surrey public sector skills academy could help develop and deliver training, building consistent values, behaviours and culture across all employees and promote cross-disciplinary learning. Any approach should be co-developed with all partners to form a Surrey workforce strategy and approach.

Programme and performance management

We are establishing a programme management capability which can manage multi-partner programmes and delivery effectively across Surrey, including effective navigation of existing system work (across the STPs/ ICSs, ICPs, Surrey County Council transformation programme etc.) Ability to monitor performance of delivery of the 10 year plan: tracking metrics, monitoring delivery from individual partners, convening partners when required to focus on underperforming areas. Ability to coordinate resources across Surrey programmes, recognise and manage interdependencies, and support interactions with other regional systems as required.

Areas of focus:

Establish a partnership programme management office (PMO) with the clear remit and responsibilities for delivery of the 10 year plan. This could be hosted by any of the existing PMOs across Surrey, or we could consider consolidating the multiple PMOs into fewer/one office to manage all programmes. This would have clear accountabilities to the decision-making group for the 10 year plan; including regular progress reports, escalation of risks and barriers for resolution etc. All partners would be aware of the office and actively feed-in progress, risks and opportunities. The use of a technology platform to enable collaboration should also be considered so project documents could be consolidated - this is particularly important given that the programme will be multi-agency.

Digital and technology

We will prioritise the work to ensure our information systems work together within and across organisational boundaries, for more efficient transfer of knowledge and information sharing; greater collaboration; and better visibility and transparency over performance data. There must be a baseline level of digital and technological maturity across the partnership - setting the foundations for further development of technology opportunities e.g. technology that allows for better and faster engagement with citizens, technology for collaboration between partners. The baseline requirement needs to be defined and established, with investment made in areas with significant gaps. A strong digital and technology approach is also key to supporting how we deliver intelligence (data and analytics) across the county.

Areas of focus:

Mapping the current digital maturity across all Surrey partners to identify gaps or barriers to in how our information systems work together (system interoperability), building on work being done by Surrey Heartlands. Understand the specific areas that need investment or a change in digital tools being used. Creating a clear and level baseline of digital maturity would be enabled by understanding those gaps, but also understanding what the long-term goal or digital ambition of the Surrey-wide system is for working with its population to improve outcomes.

Intelligence

We will build data sharing and intelligent analytics which underpin effective decision-making and provide clarity on how the system is performing. This should embed the practice of data sharing across all partners, who understand the benefit and need for effective sharing and maintaining quality information and data. It also includes an intelligence and predictive analytics capability that understands risk factors and can identify potentially high-risk individuals and groups who should be targeted for prevention. Lastly, it would also easily track the metrics required to monitor progress against outcomes in the 10 year plan.

Areas of focus:

Work has already been done to start building an analytics infrastructure across the Surrey Heartlands system that provides data-driven insights - the Surrey Office of Data Analytics (SODA). This is a virtual way of working to promote use and value of data currently held across different parts of the system. SODA will also provide a resource that can make use of new shared data infrastructure when it becomes available. This initiative, if expanded to include all Surrey partners, would effectively support the delivery of the 10 year plan, although the entire system needs to use the capability to maintain its relevance and **maximise impact.**

Devolution and alignment of incentives

Devolution allows freedoms and flexibilities so the Surrey system can align incentives across partners and eliminate financial and performance barriers to collaboration. More innovative payment mechanisms are needed to align partners' incentives to invest in prevention, influencing/signposting, and early support; and to enable partners to make operational decisions which prioritise citizen outcomes. Devolution provides an opportunity to seek the relevant powers and freedoms to do this, although devolution only covers part of the Surrey geography and partners.

Areas of focus:

Establishing a commercial model which links payments to achievement of target outcomes, including a risk and gain share which incentivises organisations to focus on prevention for the long-term benefit of Surrey and its population. Pooled budgets, as an example of a risk-sharing arrangement, would allow for the breakdown of barriers between organisations and a mechanism through which to jointly hold partners to account for collective delivery against outcomes.

In addition, the Devolution deal for Surrey Heartlands affords the region some power to negotiate additional freedoms or requests from central government that could benefit the whole of Surrey. A clear review and assessment of what may be required and potentially requested would need to be completed and agreed by Surrey's senior leadership before entering into negotiations with government. This may include requests for freedoms or deviations from the national policy in areas such as payment by results (PbR) etc.

FURTHER INFORMATION

Further information about how the Joint Health and Wellbeing Strategy has been developed can be found in the suite of appendices supporting this strategy document.

Further information about health and wellbeing in Surrey can be found on the healthy Surrey website https://www.healthysurrey.org.uk/

For any other questions about the Joint Health and Wellbeing Strategy please email us at healthandwellbeing@surreycc.gov.uk

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The NHS Long Term Plan – a summary

Find out more: **www.longtermplan.nhs.uk** | **Join the conversation:** **#NHSLongTermPlan**

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life	• reducing stillbirths and mother and child deaths during birth by 50% • ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most • providing extra support for expectant mothers at risk of premature birth • expanding support for perinatal mental health conditions • taking further action on childhood obesity • increasing funding for children and young people's mental health • bringing down waiting times for autism assessments • providing the right care for children with a learning disability • delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.
Delivering world-class care for major health problems	• preventing 150,000 heart attacks, strokes and dementia cases • providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths • saving 55,000 more lives a year by diagnosing more cancers early • investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• increasing funding for primary and community care by at least £4.5bn • bringing together different professionals to coordinate care better • helping more people to live independently at home for longer • developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • upgrading NHS staff support to people living in care homes. • improving the recognition of carers and support they receive • making further progress on care for people with dementia • giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

Health, Integration and Commissioning Select Committee

8 March 2019

Substance Misuse Service Report

Purpose of report:

In July 2018, Surrey County Council implemented changes to the commissioning of Substance Misuse treatment following a review of these services. Following engagement with service users, stakeholders and clinicians the commissioner and the service provider removed inpatient detox beds replacing these with enhanced provision in the community.

Introduction:

Each year approximately 3,000 people in Surrey seek support and treatment for alcohol and drug misuse. Their needs are primarily the dependent use of opiates (heroin), alcohol addiction and problematic use of other drugs. Access to treatment is available to those with complex needs i.e. coexisting mental health and substance misuse conditions, severe multiple disadvantage and safeguarding. This group may have less severe substance misuse issues but still require structured case management.

Over the last 2 Years Surrey County Council Public Health have carried out a variety of events forming part of a wider needs assessment for substance misuse provision. A wider needs assessment[1][2] has been used to inform the delivery of services from April 2018. The primary aim has been to ensure that post April 2018 a stable and high-quality substance misuse treatment system is maintained within a reduced financial envelope.

Surrey's substance misuse treatment system is evidence based and accessible. It performs well in a number of national indicators including the successful completion of drug treatment and recovery outcomes for the individuals who access services.[3]

The needs assessment identified where elements of service delivery could be improved, whilst making the necessary financial savings, through the integration of adult provision. This provision includes:

- Tier 2 – Low threshold substance misuse specialist interventions i.e. provision of substance misuse-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.
- Tier 3 - Care planned interventions including substitute prescribing i.e. methadone in opiate dependency, psychosocial interventions and recovery support, often provided in groups or 1 to 1 sessions with a specialist keyworker.

[1] Substance Misuse JSNA

[2] Substance Misuse Recovery Needs Assessment – Nov 2016

[3] Measuring treatment success; **Sources/background papers 4**.

- Tier 4 – Access to inpatient detoxification (see sections 2 and 3 below).
- Recovery support - includes self-help and mutual aid i.e. Alcoholics Anonymous, Narcotics Anonymous and SMART recovery, developing or reconnecting with social activities or pastimes, and education or training and employment.
- Treatment as part of Community sentences made by Courts; Drug Rehabilitation Requirements and Alcohol Treatment Requirements, Where the individual's community sentence includes agreed compliance with drug and / or alcohol misuse treatment, typically lasting between 6 months and 3 years.

Surrey County Council, following a period of consultation, decided to extend the current substance misuse treatment contract for Tiers 3 and 4 with Surrey and Borders Partnership modifying the contract to include Tier 2. Surrey and Borders with Catalyst now provide adult substance misuse treatment under the service name i-access. This enables Surrey County Council to ensure the commissioned provision of an integrated substance misuse treatment system with seamless and safe pathways within the allocated budget envelope. i-access provides treatment for dependency or substance misuse with complex need .It includes pathways for those in the Criminal Justice System.

Prior to the integration, adult substance misuse treatment was commissioned to be delivered by four primary providers each with settings or locations often exclusive to their element of treatment. The integration to one provider has improved access to treatment through the use of a single point of access, whilst maintaining three primary hubs and 29 satellite clinics across Surrey, https://www.surreydrugandalcohol.com/.

The Integration of Adult Substance Misuse Treatment was informed and benefited from the lessons learned as part of the Integration of Sexual Health and HIV services in Surrey.

1. Background:

1.1 Conditions of the public health grant require each upper tier local authority to *"…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…"* In practice this requires local authorities to commission an evidence based and accessible treatment system which comprises of **drug and alcohol treatment (including preventative and harm reduction approaches), effective pathways for those in the criminal justice system and recovery services**.

1.2 The Surrey County Council public health budget is under considerable pressure from a combination of below-target funding and national cuts to the public health grant. Ultimately, this means that by 2019/20, the overall budget available to spend on core public health programmes will be 30% less than it was at the start of 2015/16. In order to achieve this, the substance misuse treatment budget has been reduced by 24%. A collaborative co-design approach has allowed a Programme Board consisting of experts, clinicians and commissioners from Public Health Surrey County Council, Surrey and Borders Partnership Foundation Trust, Catalyst, and support from engagement with key partners including Clinical Commissioning Groups and the Criminal Justice System, to flex this limited resource to meet changes in demand for services.

1.3 The objective of the Programme Board is to maintain a stable and high-quality substance misuse treatment system that provides the capacity to meet the needs of Surrey's residents. Based on the needs assessment and to minimise disruption to the recovery journeys of service users, the decision was made to extend the provision of Substance Misuse treatment (Tiers 3 and 4) within the current terms of the contract and to modify that contract to include

Tier 2. This has enabled Surrey County Council to commission an integrated substance misuse service with seamless and safe pathways that mitigate the impact of the reduced financial envelope available for these services.

1.4 To ensure the most effective deployment of the contract budget in meeting the needs of Surrey residents open book accounting was welcomed and established between Public Health and SaBP. This transparency and co-operation has been crucial in managing the emerging pressures which are discussed further in section 5.

2. Planning the detoxification element of treatment:

2.1 From 1st July 2018, we implemented changes to how drug and alcohol detoxification is provided in Surrey. We moved inpatient services out of the existing facility (Windmill House) and provided a greater range of treatment options in the community. Access to inpatient services if required is offered out of county.

We want to make sure Surrey residents have access to high quality, evidence based care and support which considers both individual care and assessed needs and people's personal wishes and aspirations.

2.2 Who might be affected?

In the region of 3,000 people benefit from substance misuse treatment services in Surrey: of these, approximately 150 accessed inpatient detoxification at Windmill House each year. It is these individuals who are directly affected. Their families, friends and carers might also be affected.

2.3 Detoxification from alcohol and drugs is an important part of most people's treatment journey. It is part of a package of support which is tailored according to a person's individual needs. Drug and alcohol treatment programmes in Surrey prepare people carefully for their detoxification and provide **talking therapies**, either individually or in groups, to prevent relapse. i-access has a well-established and researched **abstinence preparation group** programme for people who are drinking in a dependent pattern. Where individuals are not suited to the abstinence preparation group one-to-one sessions are offered. People who are dependent on drugs are prepared for detoxification through individual sessions with their keyworker.

All people accessing treatment are encouraged to attend groups such as **SMART Recovery** and Fellowship groups such as **Alcoholics Anonymous or Narcotics Anonymous.**

2.4 Why did we transform detoxification services in Surrey?

2.5 The timing of the transformation of detoxification services was based on a number of factors:

- The Public Health budget for substance misuse services was reduced by 24% from April 2018,
- Windmill House, which provides inpatient treatment, was a fixed structure which requires a significant proportion of the substance misuse budget,
- Windmill House was situated on land at St Peter's Hospital in Chertsey that was to be sold in 2018. The significant reduction in funding available for substance misuse treatment services in Surrey means it is not possible to relocate Windmill House,
- There is an opportunity to provide more detoxification options in the community therefore allowing for greater patient choice.

2.6 Therefore, Public Health and SABP in partnership with clinicians and expertise from across **Clinical Commissioning Groups** and Adult Social Care reviewed the options for delivery of this service to ensure it is proportionate, appropriate and flexible to the needs of Surrey residents.

2.7 The aim of the review was to find an option that offers choices appropriate to need, that are safe, within the budget available and ensure the whole treatment system can meet local needs currently and in the future.

3. Meeting the detoxification needs:

What is the new model of detoxification in Surrey?

3.1 Ambulatory Detoxification from drug or alcohol dependence

This Ambulatory service is staffed Monday to Friday. The person attends a clinic every week day morning. People detoxifying from alcohol receive their detoxification medication, which is administered by a qualified nurse. They are given their night time dose as take away medication.

People detoxifying from drugs are dispensed their medication from their identified community pharmacy.

Programme participants attend a support group run by a trained group facilitator. If necessary, a nurse gives additional medication according to the person's individual need. The programme finishes at lunchtime; lunch is provided and starts again the following weekday morning. Most alcohol detoxification programmes will last between five to ten days and people are given medication for the weekend.

Drug detoxification programmes vary according to the person's individual needs, but those who need additional support will be invited to attend the ambulatory detoxification programme for the final two weeks of their reduction regime.

This service is available at two clinic locations in Surrey: Farnham Road Hospital in Guildford and Wingfield Resource Centre in Redhill.

Where a person's journey to the service is challenging i-access have provided additional transport often this is the use of a taxi.

3.2 Home Detoxification from alcohol dependence

Home detoxification lasts between five to ten days. A person receives daily home visits lasting around an hour, from a qualified nurse who supervises, monitors progress, supports and carries out regular health checks.

3.3 Community Detoxification from drug dependence

Community detoxification is provided according to a person's needs. The person will be supervised, monitored and supported during frequent appointments with a qualified worker at one of our service locations.

3.4 Access to residential/inpatient detoxification

Inpatient detoxification from drug or alcohol dependence is offered to people who have **complex needs** and for whom a home or ambulatory detoxification is not appropriate and/or safe.

The location will be reviewed with the individual and will be outside of Surrey. The individual is supported to access treatment and provided with a care package which supports a smooth transition back to Surrey.

SABP has sourced an appropriate NHS provider; Bridge House at Fant Oast. We have ensured the organisation that provides this service is of the highest quality and meets the standards expected by the **Care Quality Commission,** with minimum standards of 'good'[4].

3.5 Delivery of the new detoxification model

Following the introduction of the new model for detoxification on 1st July 2018, 52 individuals have undertaken an ambulatory detoxification, an additional nine attended the intensive recovery group as part of the ambulatory programme, one person has had a home detoxification and two people have attended an inpatient detoxification at an out of county facility in each of these cases in Kent.

Of these 64 individuals, 13 were previously unknown to i-access, their treatment was transferred from one of the Acute hospitals to the i-access ambulatory detox service. Transfer from these hospitals to i-access is an innovative approach which has improved access to specialist treatment in Surrey. This arose and developed from the detoxification public consultation conducted between March and May in 2018.

Each month the number of people attending ambulatory detoxification has increased, we acknowledge that the changes in the model took place over a short 3 month period, to avoid confusion i-access have continued to discuss and promote the changes to detoxification with individuals and groups who use the service and with key partners particularly referrers i.e. Primary Care, Adult Social Care and Children Families and Learning.

3.6 Service user feedback

i-access seeks feedback throughout an individual's treatment journey and provides a summary to Public Health on a quarterly basis. People who have used the detoxification options since July rated their experience as positive and would recommend the service to friends and family.

They said:

- *"It was very therapeutic to talk through issues around addiction with experts and peers. The groups were intimate and caring, a place to be honest with yourself and others and learn"*
- *"Wouldn't have been able to "cross the line" without your support/help and friendliness"*

[4] Bridge House at Fant Oast, Kent and Medway NHS and Social Care Partnership Trust. Care Quality Commission Report

- *"Very grateful for taxi to and from i-access. I have learned a lot from the tutor and others in the group. Not only positive but motivational and inspirational – it has given me hope"*

Following the open meetings held as part of the detoxification public consultation in 2018 i-access are planning an open meeting to be held twice a year, The first is scheduled for Spelthorne in March 2019 and will discuss substance misuse treatment including detoxification and recovery.

3.7 Detoxification evaluation

There is a Drug and Alcohol Detoxification Service Evaluation to identify the impacts of the change in the detoxification service model including the following points: referral, accessibility, impacts on other services, outcomes for individuals who use the detoxification service and acceptability of the new model to services users and partner organisations. The evaluation which begun in July 2018 is being undertaken by a Public Health Speciality Registrar and is scheduled to be published in August 2019.

4. Risks and mitigations:

4.1 Public Health are committed to a co-design approach to support the provider partners to be innovative in exploring new delivery options whilst ensuring that traditional methods are used for those who require them.

4.2 The integration of the tiers 2, 3 & 4 substance misuse treatment has primarily eased access to treatment[5], strengthened care pathways and improved outcomes for service users. We do however acknowledge that the mobilisation of the service under the budget challenges could have resulted in possible risk to the stability of the system; we therefore chose a model of co-design, undertaken with specialist providers to continue to ensure and build on stability.

4.3 It is a national requirement and a local quality expectation that treatment for substance misuse begins within 21 days following a referral although the average wait for Surrey is 14 days. There has not been any identified negative impacts to health and social care partners as a result of the integration, however, the Public Health commissioning lead, the multi-agency Substance Misuse Programme Board and The Surrey Substance Misuse Partnership are available to resolve possible concerns that may arise.

4.4 Previous provision for in-patient complex needs detoxification (T4) was at Windmill House in Chertsey an 11 bed ward provided by SaBP. Windmill House was closed in July 2018.

4.5 In the South-East region, there has been a move towards commissioning "spot purchase" of in-patient provision. There has been a number of closures of NHS in-patient facilities (Baytrees Hampshire and Matt Gladd Centre CNWL) resulting in a reduction and limited provision in the region. The process of procuring an integrated service will need to ensure ongoing accessible provision of good quality Tier 4 services for Surrey residents.

[5] Treatment locations 2019; **Sources/background papers 3**.

4.6 A Programme Board has been developed to ensure that those with related specialist knowledge and expertise are able engage in the development of the specification and the service. The Terms of Reference are developed and accountability sits with the Public Health Leadership team, SaBP Leadership and the Catalyst Board of Trustees.

5. Emerging pressures:

5.1 Cost pressures

Since March 2018 a pharmaceutical "price concession" has been applied each month to the cost of an opiate substitute therapy (OST) medicine called Buprenorphine, this has resulted in a projected budget cost pressure of £220,000 at year end. As a result of the cost pressure some specialist posts, planned treatment and "wrap around" detoxification support has been deferred to mitigate against a negative impact to successful outcomes for service users.

The Programme Board has a monthly telephone conference to monitor and plan our response to the cost pressure, actions from the conference have included:

1. A review of national and local clinical guidelines and practice.
2. The transfer of some individuals where appropriate to other OST medication.
3. Introduction to the treatment programme of a newly available alternative OST medication.

In amendments to the NHS drug tariff (January 2019) the price of Buprenorphine has been removed from "price concession" and the price was increased in the tariff, in comparison to the stable price in February 2018 this represents a 702% cost increase, this means in "a worst case scenario" during 2019/20 that the i-access budget will have a cost pressure of £301,000; the cost pressure is based on comparative increase in the cost of Buprenorphine prescribed in February 2018 (£3,123) and January 2019 (£25,072).

On 13/02/2019 Professor John Newton wrote to Directors of Public Health with Buprenorphine advice from PHE detailing the move from price concession to tariff to category A and including the recommendation, "It is vital that the new higher cost of medicines is considered by local authorities when setting their budgets and capacity targets for drug treatment. There should be an acceptance that previous budgets and capacity targets were based on lower medicines costs, and the recent increases should not be seen as a temporary situation only needing short-term management."[6]

5.2 Access to treatment

The numbers of people accessing substance misuse treatment in Surrey, when comparing quarter 2 2016/17 and quarter 2 2018/19, has increased. Those presenting with an alcohol dependency increased by 71% (177) and with an opiate dependency 12% (21), there are also increases in "alcohol and non-opiate" and "non-opiate" presentation although the proportions of change are currently more difficult to identify.

[6] Buprenorphine – advice from PHE, **Sources/background papers 2.**

6. How do we measure success:

6.1 As stated in paragraph 2.3, Detoxification from alcohol and drugs is an important part of most people's treatment journey and is part of a package of support which is tailored according to a person's individual need. i-access and Public Health, via a quarterly contract review with the oversight from the Programme Board, monitor access to, the quality and outcomes to all elements of people's treatment and recovery journeys.

6.2 Overall performance for adult substance misuse treatment can be distilled into 2 primary measures:

1. **Wait times: percentage of clients waiting over three weeks for their first intervention** – for Surrey this is predominantly 0%, although we are aware that 3 of the 415 people who were "new to treatment" at one hub in Surrey during the first 6 months of 2018/19 waited longer than 21 days.
2. **Successful completion of drug treatment (includes alcohol)** which measures those who leave treatment and don't re-present within six months –in Surrey for opiates and alcohol this is similar to comparator Local Authorities and non-opiates this is better. (Public Health Outcomes Framework 2.15) [7]

Conclusions:

1. The new detoxification model developed has responded effectively to the presenting need, the model has broadened routes of access for those not in contact with specialist treatment (i-access) in the use of a care coordinated pathway with the Acute Hospitals in Surrey.
2. People who have been seen by the detoxification team have given positive feedback about their treatment.
3. There is a current and ongoing significant financial risk in the costs of medication used in Opiate Substitute Treatment. These risks have been managed with in the contract budget with the support of the open book accounting model and with the Programme Board oversight.
4. Over a 3 year period there has been an increase in the number of people presenting for drug and alcohol misuse treatment in Surrey.
5. The Programme Board has effectively managed the substantial changes in the integration of adult treatment services, the remodelling of detoxification, an increase in the number of people accessing treatment and the Buprenorphine cost pressure.
6. Integration of adult substance misuse treatment service was led by a partnership that brought together Surrey County Council, Surrey and Borders Partnership NHS Foundation Trust and Catalyst, it is recognised that this approach has improved relationships between these three sectors and strengthened the network of resources that can be drawn upon to strengthen resident's recovery journeys.

[7] Measuring treatment success; **Sources/background papers 4**.

Recommendations:

The Health, Integration and Commissioning Select Committee:

I. note the progress made in the changes to the adult substance misuse treatment system;

II. invite the Programme Board to update the committee on:
   a. Drug and Alcohol Detoxification Service Evaluation scheduled to be published in October 2019.
   b. Performance of the adult drug and alcohol misuse treatment system.

Next steps:

Service Development post 2020
Co-design and continuous development will be central to provision over the next year. It has been recognised that the health and social care landscape is evolving and developing in a way which supports a co-design approach reinforcing Surrey's drive towards integrating provision and exploring new ways of commissioners and providers working in partnership to deliver improved standards of care. The integrated substance misuse service has been mobilised, Surrey County Council Public Health will now begin to develop commissioning intentions for April 2020. This will take into consideration changes as a result of Sustainability and Transformation Partnerships and Devolution.

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Sources/Background papers:

Annex 1- i-access Service Users Leaflet
Annex 2- Drug Information Guidance
Annex 3- Buprenorphine Advice from PHE
Annex 4- Service Wide Map 2019

Access to treatment:
The numbers of people accessing substance misuse treatment in Surrey, when comparing quarter 2 2016/17 and quarter 2 2018/19, has increased. Those presenting with an alcohol dependency increased by 71% (177) and with an opiate dependency 12% (21), there are also increases in "alcohol and non-opiate" and "non-opiate" presentation although the proportions of change are currently more difficult to identify.

Wait times:
Percentage of clients waiting over three weeks for their first intervention – for Surrey this is predominantly 0%, although we are aware that 3 of the 415 people who were new to treatment at one hub in Surrey during the first 6 months of 2018/19 waited longer than 21 days. The average wait time in Surrey is 14 days.

Successful completions of treatment
Public Health Outcomes Framework (PHOF) 2.15 i/ii/iii measures the rate of individuals who successful leave treatment and do not represent within the following 6 months. Figure 1 below shows the performance of the Surrey treatment system compared to the previous baseline period, the direction of travel (D.O.T.) for each of the drug categories is marked with a green arrowhead and indicates increased performance. In the latest period marked as percentage (%) opiate performance is similar to Local Authority comparators, non-opiate is higher and alcohol is similar to comparators. It should be noted that although the integrated service began to delivery in April 2018/19 the quarter 2 data is the latest available although PHOF 2.15 in figure 1 is derived from the previous year's performance data.

PUBLIC HEALTH OUTCOME FRAMEWORK: INDICATOR 2.15 - Successful completion of drug treatment

1.1 Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months (PHOF 2.15 i/ii/iii)

(n) = number successfully completed and did not re-present / all in treatment
Baseline period: Completion period: 01/10/2016 to 30/09/2017, Re-presentations up to: 31/03/2018
Latest Period: Completion period: 01/04/2017 to 31/03/2018, Re-presentations up to: 30/09/2018
Comparison to England: Lower = Red, Similar = Amber, Higher = Green
Direction of travel (D.O.T): Current data measured against the baseline (B). Due to rounding small differences may not be visible in displayed percentages, but are taken into account in D.O.T. calculation.
Note: PHOF 2.15 has been refreshed in line with http://www.phoutcomes.info and https://www.ndtms.net

	Baseline period		D.O.T	Latest period		Top Quartile range for Comparator LAs	Range to achieve Top Quartile
	(%)	(n)	B	(%)	(n)		
Local opiate clients	6.4%	84 / 1305	▲	6.8%	84 / 1240	7.89% - 12.73%	98 to 157
National opiate clients	6.6%			6.3%			
Local non-opiate clients	40.2%	305 / 758	▲	48.9%	370 / 756	43.84% - 54.16%	332 to 409
National non-opiate clients	36.6%			36.4%			
Local alcohol clients	22.8%	220 / 963	▲	37.4%	392 / 1048		
National alcohol clients	38.6%			39.0%			

Fig 1. PHOF 2.15 Quarter 2 2018/19

Successful completions:
The number and proportion of clients in treatment in the latest 12 months who successfully completed treatment

Re-presentations:
The number and proportion of clients in treatment in the latest 12 months who successfully completed treatment.

Glossary of acronyms:

Alcoholics anonymous

AA is concerned solely with the personal recovery and continued sobriety of individual alcoholics who turn to the Fellowship for help. Alcoholics Anonymous does not engage in the fields of alcoholism research, medical or psychiatric treatment, education, or advocacy in any form, although members may participate in such activities as individuals. https://www.alcoholics-anonymous.org.uk/About-AA/What-is-AA

Catalyst

Catalyst is a Surrey based non-profit organisation working with people who are dealing with issues stemming from drug and alcohol misuse and mental health, reducing the harm to themselves, their families and communities. www.catalystsupport.org.uk

Needs Assessments

Health needs assessment (HNA) is an essential tool to inform commissioning and service planning, and can be defined as a systematic method of identifying the unmet health and healthcare needs of a population, and making changes to meet those unmet needs.[i]

Narcotics Anonymous

N.A. is a non-profit fellowship or society of men and women for whom drugs had become a major problem. We are recovering addicts who meet regularly to help each other stay clean http://ukna.org/content/what-na

Public Health Outcomes Framework (PHOF)

The Public Health Outcomes Framework examines indicators that help us understand trends in public health. https://www.gov.uk/government/collections/public-health-outcomes-framework

Psychosocial interventions

Psychosocial interventions for treatment of alcohol and drug problems cover a broad array of treatment interventions, which have varied theoretical backgrounds. They are aimed at eliciting changes in the patient's drug use behaviors well as other factors such as cognition and emotion using the interaction between therapist and patient. Typically they would include Brief opportunistic intervention, Motivational Interviewing and Cognitive Behavioral Therapies.

SaBP

Surrey and Borders Partnership NHS Foundation Trust is the leading provider of health and social care services for people of all ages with mental ill-health and learning disabilities in Surrey & North East Hampshire and drug & alcohol services in Surrey and Brighton. www.sabp.nhs.uk

SMART Recovery

SMART Recovery (SMART) is a science-based programme to help people manage their recovery from any type of addictive behaviour. This includes addictive behaviour with substances such as alcohol, nicotine or drugs, or compulsive behaviours such as gambling, sex, eating, shopping, self-harming and so on. SMART stands for 'Self Management and Recovery Training'. https://www.smartrecovery.org.uk/about/

Talking Therapies

Talking therapy is for anyone experiencing negative thoughts and feelings or who is feeling distressed by emotional or mental health problems, or difficult events in their lives which they can't sort out on their own. Sometimes it's easier to talk to a stranger than to relatives or friends. During talking therapy, a trained counsellor or therapist listens to you and helps you find your own answers to problems, without judging you.

https://www.nhs.uk/conditions/stress-anxiety-depression/benefits-of-talking-therapy/

http://www.sabp.nhs.uk/services/mental-health/adult/community/mind-matters-surrey

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[i] **Health Knowledge**
https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/uses-epidemiology-health-service-needs

Contact us

Our trained staff are available Monday – Friday, 9am – 5pm to take referrals or to give advice on drug and alcohol use.

Tel: 0300 222 5932
Email (confidential): rxx.iaccess@nhs.net

Post: Laurel House, Farnham Road Hospital, Farnham Road, Guildford GU2 7LX

Web: www.surreydrugandalcohol.com

@iaccess_Surrey

Useful contacts

Catalyst: 01483 590 150
www.catalystsupport.org.uk

SDAC - Surrey Drug and Alcohol Care: 0808 802 5000

Don't bottle it up: www.dontbottleitup.org.uk

Drink Line: 0300 123 1110

Talk to Frank (24/7): 0300 123 6600

Alcoholics Anonymous: 0845 769 7555

Narcotics Anonymous: 0300 999 1212

Cocaine Anonymous: 0800 612 0225

Find out more

If you would like this information in another format or another language:

Tel: 01372 216285
email: communications@sabp.nhs.uk

Surrey and Borders Partnership
NHS Foundation Trust
18 Mole Business Park, Leatherhead,
Surrey KT22 7AD

Tel: 0300 55 55 222
Textphone: 020 8964 6326
www.sabp.nhs.uk
@sabpnhs facebook.com/sabpnhs

Publication ref: A72404/i-access_help/V2
Publication date: April 2018

catalyst
HELPING PEOPLE CHANGE

i-access
Drug & Alcohol Services

Drug and alcohol help in Surrey

NHS
Surrey and Borders Partnership
NHS Foundation Trust

About us

We offer specialist assessment, support and treatment to people in Surrey who want help with their problematic drug use and those who are dependent on alcohol and want to stop or control their drinking.

We do this in partnership with Catalyst, a specialist non-profit organisation based in Surrey who work with people with issues arising from drugs, alcohol and mental health.

All staff are highly skilled and experienced at helping people affected by drug and alcohol misuse, their families and carers.

How to get help

You can contact us yourself either over the phone (details on back page) or in person to see if we can help you. We also accept referrals from GPs and other referral agencies.

Getting in touch with us directly helps us to get to know you and understand your needs better from the beginning. We will write to your GP and keep them informed about your recovery care plan and progress and we have an obligation to tell them about any medication we prescribe for you.

When we receive your information, we review all your details and consider the next steps and what will work best for you. If our service isn't right for you, we'll refer you on to a more suitable service that we think will be able to help you.

How we can help

If our service is right for you, we'll offer you an appointment for an assessment. This may be by telephone or in person at one of our clinics in Surrey. Once this has taken place we will develop a personalised recovery care plan with you.

The services we offer include:

- One-to-one sessions
- Peer mentoring
- Recovery support
- Counselling
- Pregnancy support
- Home/ambulatory detoxification
- Needle exchange
- Hepatitis A & B vaccination and Hepatitis C testing
- Support for dependent alcohol users who want to make some changes but do not wish to stop drinking.

"The staff are all very warm, kind and easy to talk to which makes discussing my problems easier - especially as it's a delicate subject."

Group work including

- Relapse prevention
- Health and wellbeing
- Abstinence preparation
- Recovery Café
- Non-abstinence
- Women's group
- SMART.

You'll meet your key worker at one of our locations in Surrey. Where possible you can choose where you are seen and we offer daytime and evening appointments to fit around your schedule.

Concerned about someone?

If you're supporting or caring for someone who has drug or alcohol problems, our Carers' Liaison Officer can help you. Please call 0300 222 5932 for advice.

The following organisations can also help:

Families Anonymous: 0845 1200 660

Al-Anon & Alateen: 020 7403 0888

Adfam: www.adfam.org.uk

Taking the first step

You can contact us to book a confidential assessment to discuss your needs and concerns around your health, wellbeing and drug use. With your permission, information from assessment will be used to create a personal plan to meet your individual goals.

After assessment we offer two guaranteed face to face sessions around areas such as:

- **Harm reduction advice on drug use**
- **Health and wellbeing self help**
- **Change motivation**
- **Progress review**
- **Signposting and further help if required**

If you need more support we would do a more detailed assessment and develop your plan with you.

We are committed to protecting the privacy and security of personal and confidential data/information.

"offering a friendly, respectful, non-judgemental and personal approach"

Get in touch

You can **self-refer** or ask a professional supporting you to make a referral to:

TEL: 0300 222 5932

CONFIDENTIAL EMAIL: rxx.iaccess@nhs.net
ONLINE: www.surreydrugandalcohol.com
POST: Laurel House, Farnham Road Hospital, Guildford GU2 7LX

What happens after the referral?

- We offer you an initial assessment by phone or face to face.
- The face-to-face assessment can be at one of our three main sites; Guildford, Chertsey or Redhill, or we have other venues. Please ask when we contact you for an assessment.

@iaccess_Surrey

@CATALYSTETHOS

Using Cocaine, Cannabis, Steroids or other drugs?

What help can you get?

Image and Performance Enhancing Drugs'

i-access Drug & Alcohol Services in partnership with catalyst HELPING PEOPLE CHANGE

How we help:

We can offer up to 12 sessions of support which could include one or more of the following:

- One-to-one and/or group support based around your goals
- Exploring options to change drug use
- Identifying high-risk situations and solutions
- Developing skills to manage situations and other emotions
- Dealing with triggers for craving
- Managing stress
- Relapse prevention and coping methods
- Attaining a life-style balance
- Alternatives to drug use
- Providing information on other services and groups to support you
- Providing you with information or referral to other services with your permission e.g. counselling, Wellbeing Activities, Mental Health Services

We provide advice and support to reduce harm

Taking drugs carries risk and can potentially be harmful, if you choose to take them. Please bear in mind the following points for safer use:

HARM REDUCTION SAVES LIVES

- **Start low (dosage), go slow.** Many substances aren't pure, they vary in strength and could affect how long it takes for the effects to kick in
- Risk increases with frequency, **try cutting down** the amount of times you use
- Try and **buy from a trusted source**
- **Don't drive or operate vehicles** while under the influence
- Choose a **safe environment** to use in, to prevent harm to yourself and others
- **Educate yourself** about your rights, health risks, laws and consequences of using
- **Stay hydrated**
- **Don't use alone**
- **Avoid** using drugs to deal with emotions
- **Do not mix** drugs with other substances, this will increase the risk
- Ensure you allow yourself time to recover afterwards, with plenty of rest, sleep, fluids and **nutrients i.e vitamins, food, water**

We do not promote the use of illegal psychoactive substances. This content is strictly for harm reduction purposes.

Public Health England

Protecting and improving the nation's health

Health Improvement
Wellington House
133 to 155 Waterloo Road
London
SE1 8UD

T +44 (0) 20 7654 8032
www.gov.uk/phe

Attn: Directors of Public Health

Buprenorphine – advice from PHE (3)
Gateway number: L2018-450

13th February 2019

Dear Director of Public Health,

Buprenorphine used in the treatment of opioid dependence: availability and price

You may recall that I wrote to you in May and October last year (appended) about concerns over the availability and price of buprenorphine tablets used in the treatment of opioid dependence. This further communication contains an update on the latest information about buprenorphine pricing and some important recommendations for local authorities in relation to this, as well as some advice in relation to EU exit and medicines supply.

Update on buprenorphine pricing

In April 2018 the selling price had risen above the reimbursement price in the Drug Tariff (DT), which sets out what will be paid to pharmacies dispensing under the NHS Pharmaceutical and Local Pharmaceutical Service Regulations. As a result the Department of Health and Social Care (DHSC) set a concessionary price. The selling price remained higher than the reimbursement price and, until last month, concessionary prices therefore continued to be paid. Last month 2mg and 8mg buprenorphine tablets were moved from category M of the Drug Tariff to category A, at higher prices than the previous DT prices and even higher than the concessionary prices:

Price per 7 tablets (£)	DT price Jan 2019	Concessionary prices 2018									DT price Apr 2018
		Dec	Nov	Oct	Sep	Aug	Jul	Jun	May	Apr	
Buprenorphine 2mg s/l tablets SF	6.67	5.38	5.19	5.25	5.35	4.78	4.87	5.24	6.35	1.33	0.93
Buprenorphine 8mg s/l tablets SF	19.19	13.70	14.03	15.40	15.74	8.91	12.01	10.90	16.15	2.38	1.81

This change means that a continuing increased cost for drug treatment providers and/or their commissioners is likely, with no sign that this will end, as I predicted might be the case when I wrote in October.

PHE has continued to work closely with DHSC, and with drug treatment providers, to understand the issues and their impact, and what can be done to mitigate any resulting problems. Drug treatment providers and their local authority commissioners have worked together on these mitigations, which include alternative (and currently cheaper) formulations of buprenorphine, more rigorous application of criteria on the choice between buprenorphine and methadone, and reducing other services, etc. In many cases, these mitigations are in addition to finding additional funds to cover the increased costs already experienced. These creative and flexible solutions in very challenging circumstances are testament to the clinical expertise of services and their clinicians, the good working relationships between commissioners and their commissioned services, and commissioners' financial and contracting skill.

Recommendations for local authorities in light of changes to buprenorphine pricing

It is vital that the new higher cost of medicines is considered by local authorities when setting their budgets and capacity targets for drug treatment. There should be an acceptance that previous budgets and capacity targets were based on lower medicines costs, and the recent increases should not be seen as a temporary situation only needing short-term management.

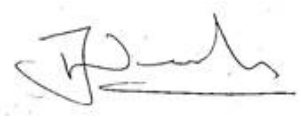
EU exit and medicines supply

Some reports are attempting to link medicines shortages to a potential no-deal Brexit but DHSC has not seen any evidence to support this. I would like to reiterate the messages from DHSC and NHS England that it is not helpful or appropriate for anyone to stockpile medicines locally. Stockpiling in one area can risk additional pressure on the availability of medicines for patients in other areas of the country.

A recent letter from Dr Keith Ridge, Chief Pharmaceutical Officer, outlines the steps taken by the NHS thus far to protect the continuity of supply for medicines. This letter usefully provides contact details for regional leads who will be working closely with regional pharmacists. Your commissioners will want to assure themselves that drug and alcohol services provided by the NHS and third sector providers, particularly smaller organisations, have sought appropriate advice from pharmacy and medicines management specialists locally, and had reassurance from suppliers about stock levels.

You may find it beneficial to consult with NHS pharmacy leaders who are also well placed to provide information and advice to patients and other health professionals about the plans for continuity of supply, and this should be a priority over the coming weeks.

Yours faithfully,



Professor John Newton
Director of Health Improvement

Public Health England

Protecting and improving the nation's health

Professor John Newton
Director of Health Improvement
7th floor Wellington House
133 – 155 Waterloo Road
London SE1 8UG

24 October 2018

Gateway number: L2018-443

Dear Director of Public Health,

Buprenorphine used in the treatment of opioid dependence: availability and price

You may recall that I wrote to you in May (appended) about concerns over the availability and price of buprenorphine tablets used in treatment of opioid dependence.

In April the selling price had risen above the reimbursement price listed in Part VIIIA of the Drug Tariff, which sets out what will be paid to pharmacies dispensing under the NHS Pharmaceutical and Local Pharmaceutical Service Regulations. As a result the Department of Health and Social Care (DHSC) set a concessionary price. The selling price has remained higher than the reimbursement price and concessionary prices have therefore continued to be paid as follows:

Price per 7 tablets	Concessionary prices							Drug Tariff price (April)
	Oct	Sept	Aug	July	June	May	April	
Buprenorphine 2mg s/l tablets SF	5.25	5.35	4.78	4.87	5.24	6.35	1.33	0.93
Buprenorphine 8mg s/l tablets SF	15.40	15.74	8.91	12.01	10.90	16.15	2.38	1.81

PHE has continued to work closely with DHSC, and with drug treatment providers, to understand the issues and their impact and what can be done to mitigate any resulting problems.

Availability

Although the original supply issue has been resolved, supplies of the generic buprenorphine have been limited and pharmacists have had to rely on obtaining and supplying branded buprenorphine.

Price

Branded buprenorphine is more expensive than the generic product but pharmacists are paid as set out in the Drug Tariff (or the concessionary price) for whichever product they dispense against a prescription for generic buprenorphine. This reimbursement price can change according to market conditions as, in the main, reimbursement arrangements reflect selling prices. So, for example, if a selling price increases, it will be reflected in reimbursement prices.

These price increases mean that drug treatment services and their commissioners will see increased drugs bills for most, if not all, of 2018 and potentially beyond that. This is already creating some serious financial pressures.

It is impossible to predict for how long a higher concessionary price will continue to be paid. Eventually concessionary prices will no longer be required, either because the reimbursement prices listed in the Drug Tariff will catch up with the increased selling prices or because selling prices will decrease to the original level. Previous experience suggests that it is usually the former rather than the latter. **Now and looking to the future, local authorities may need to reflect on the medicines element in their budgets for drug treatment.**

Legal issues

In relation to considering prescribing alternatives to buprenorphine, a NICE-recommended treatment (TA114), clinicians in the drug treatment services you commission will understand the relative pros and cons of the different medicines, and the patients for whom they can be more effective.

There is a legal obligation under the NHS Constitution for the NHS and local authority public health services to fund and resource medicines and treatments recommended by NICE's technology appraisals, if a doctor says they are clinically appropriate for a patient.

Yours faithfully

Professor John Newton
Director of Health Improvement

Public Health England

Protecting and improving the nation's health

Professor John Newton
Director of Health Improvement
7th floor Wellington House
133 – 155 Waterloo Road
London SE1 8UG

Gateway number: 2018117

25 May 2018

Dear Director of Public Health,

Buprenorphine used in the treatment of opioid dependence: availability and price

Some drug treatment services, and the pharmacists who dispense the medicines they prescribe, have raised concerns about the availability of generic 2mg buprenorphine tablets, and about the price that pharmacists are paid for them when they dispense NHS prescriptions.

PHE has been working closely with the Department of Health and Social Care (DHSC) to understand the issues and what can be done to mitigate any resulting problems. Please share the information that follows with your drug treatment commissioner and providers.

Availability

Although one manufacturer of generic buprenorphine had a production issue, DHSC have confirmed that supplies of other generic buprenorphine and of Subutex-branded buprenorphine continue to be available from other manufacturers. DHSC will continue to work with suppliers to understand their volumes and delivery dates.

Price

Branded buprenorphine is more expensive than the generic product but pharmacists are paid a standard, agreed price as set out in the Drug Tariff for whichever product they dispense against a prescription for generic buprenorphine. This reimbursement price can change according to market conditions if a concessionary price is granted.

DHSC have told us:

> "The generic market is a competitive one and prices fluctuate up and down constantly. Concessionary prices are granted for products, which are unavailable to pharmacy contractors at or below the reimbursement price listed in Part VIII of the Drug Tariff.
>
> If a concessionary price is granted, it applies to prescriptions dispensed in the month, in which the concessionary price was granted. Products, which are granted concessionary prices in subsequent months, are still considered on a monthly basis. Therefore, it is not possible to give any advance notice of granting concessionary prices or to predict for how long a product will be granted a concessionary price.
>
> The following concessionary prices were granted for buprenorphine sublingual tablets sugar free:
>
> April
> - Buprenorphine 2mg sublingual tablets sugar free (7) - £1.35
> - Buprenorphine 8mg sublingual tablets sugar free (7) - £2.39
>
> May
> - Buprenorphine 2mg sublingual tablets sugar free (7) - £6.35
> - Buprenorphine 8mg sublingual tablets sugar free (7) - £16.15
>
> As soon as concessionary prices are granted, they are published on the NHS BSA's website." (www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff/drug-tariff-updates)

Prices are also published on the website of the Pharmaceutical Services Negotiating Committee (PSNC) at https://psnc.org.uk/dispensing-supply/supply-chain/generic-shortages/

The non-concessionary Drug Tariff prices that applied before April were:

- Buprenorphine 2mg sublingual tablets sugar free (7) - £0.93
- Buprenorphine 8mg sublingual tablets sugar free (7) - £1.81

The Drug Tariff prices of these products are amended every quarter (April, July, October and January) to take account of historic sales and volume using data supplied to the DHSC from suppliers. Therefore there may be a change in the underlying reimbursement price of these products later in the year.

www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff

These temporary, or any ongoing, price increases mean drug treatment services and their commissioners will see increased drugs bills for April and May, and these increases may continue. They will occur whether pharmacists dispense generic or branded buprenorphine.

Drug treatment services that usually pay the drugs bill as part of their contracted service may approach their commissioners to discuss the impact of these extra costs – how this is managed is for local agreement.

The NHS is used to managing these unavoidable fluctuations in the cost of medicines and can often balance an increase in some medicines with decreases in others. However, in specialist services – such as some commissioned by local authorities – the range of medicines used is often limited and there is less experience of managing fluctuations and less scope for them to be managed. Local authority commissioners and their services may be able to benefit from the NHS's experience and expertise through advice from local partnerships and contacts, including CCG medicines management teams. PHE will continue to do all it can with DHSC to ensure the continuation of supply.

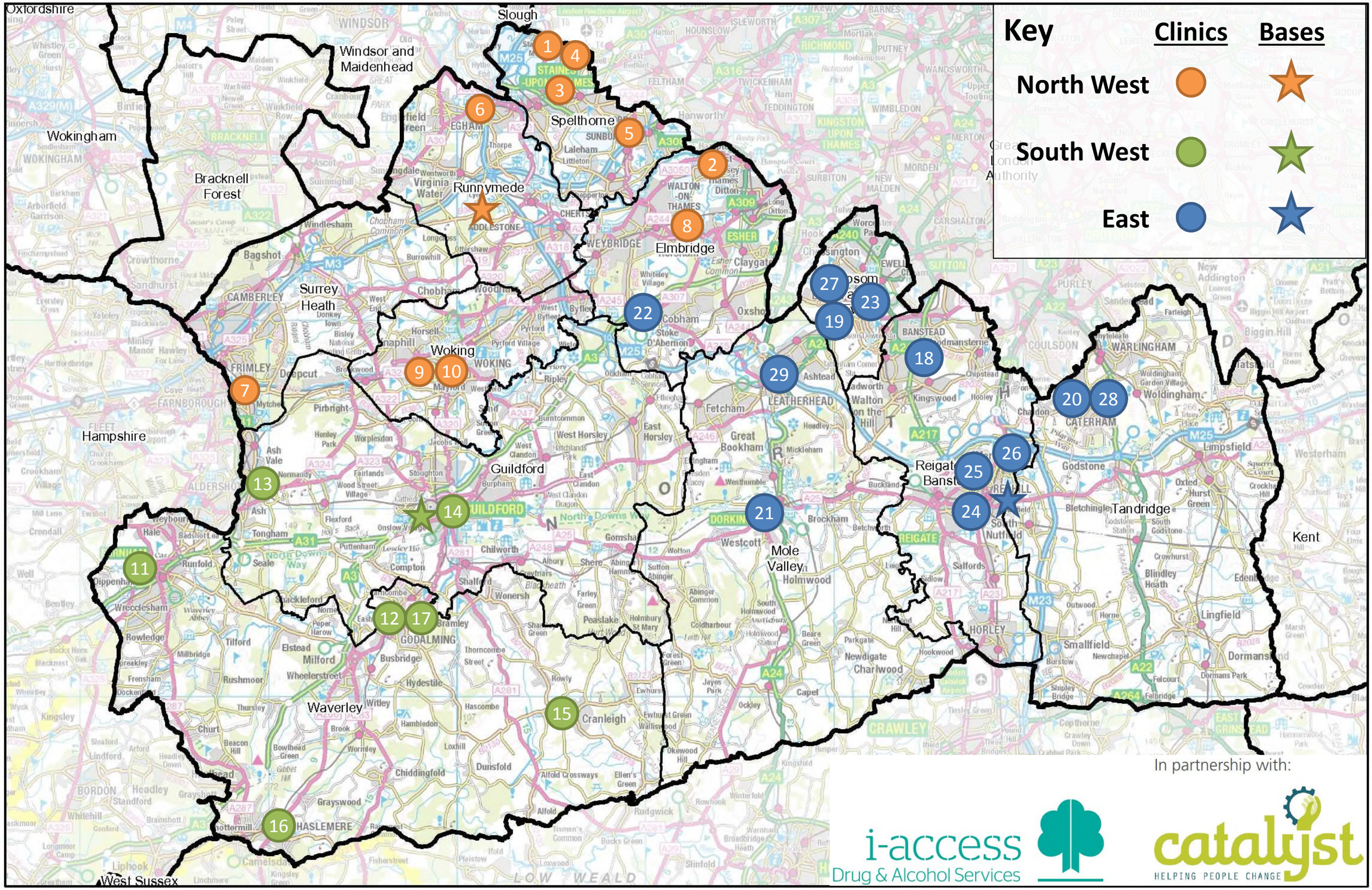
Clinical issues

One final issue that drug treatment clinicians may want to consider is the relative bioavailability of different buprenorphine formulations and products. There is no agreed clinical guidance, and no reports of patient impacts in clinical practice, but clinicians will want to be alert to the theoretical possibility that a different product might result in a different clinical response. During switching from one product to another, clinicians will want to carefully monitor the transition and consider adjusting the prescribed dose.

Yours faithfully

Professor John Newton
Director of Health Improvement

i-access Bases and Clinics February 2019



In partnership with:

i-access Drug & Alcohol Services

catalyst HELPING PEOPLE CHANGE

Borough and District Boundaries in Surrey

Surrey
Districts and Boroughs

Original Size A4

Printed By: GIS Team
Printed On: Feb 2015
Project No: F0748269
Scale: 1:250,000

i-access Bases and Clinics February 2019

i-access North West

Abraham Cowley Unit, Holloway Hill, Chertsey, KT16 0AE

1	Ashford Health Centre	Ashford Hospital, London Road, Ashford, TW15 3FE
2	Joseph Palmer Centre	319 Walton Road, Molesey, West Molesey, KT8 2QG
3	Knowle Green Medical Centre	Knowle Green, Staines, TW18 1XD
4	St David's Health Centre Surgery	Hadrian way, Stanwell, Staines, TW19 7HT
5	Sunbury Health Centre	Green Street, Sunbury on Thames, TW16 6RH
6	The Hythe Medical Centre	83 Rochester Road, Staines upon Thames, TW18 3HN
7	Theta clinic	Lyons Way, Frimley, Surrey, GU16 7ER
8	Walton Community Hospital	Rodney Road, Walton on Thames, KT12 3LB
9	Woking Community Hospital	Heathside Road, Woking, GU22 7HS
10	Xchange	20 High Street, Woking, Surrey, GU21 6BW

i-access South West

Laurel House, Farnham Road Hospital, Guildford, GU2 7LX

11	40 Degreez	Dogflud Way, Farnham, Surrey, GU9 7UT
12	9 Queen Street	Godalming, GU7 1BA
13	Ash Vale Health Centre,	Wharf Road, Ash Vale, Surrey, GU12 5BA
14	Catalyst Guildford	14 Jenner Road, Guildford, GU1 3PL
15	Cranleigh Medical Practice	18 High Street, Cranleigh, Surrey, GU6 8AE
16	Hasleway Community Centre	Lion Green, Haslemere, GU27 1LD
17	The Mill Medical Practice	Cattershall Mill, Godalming, GU7 1JW

i-access East

Wingfield Resource Centre, St Annes Drive, Redhill, RH1 1AU

18	Banstead Clinic	The Horseshoe, Bolters Lane, Banstead, SM7 2BQ
19	Brickfield Centre	Portland Place, Epsom, KT17 1DL
20	Caterham Valley Medical Practice	Caterham, CR3 6JA
21	Clarendon House	28 West Street, Dorking RH4 1QJ
22	Cobham Health Centre	168 Portsmouth Road, Cobham, KT11 1HT
23	Epsom General Hospital	Langley Wing, Epsom General Hospital, KT18 7EG
24	Gatton Place	St Matthew's Road, Redhill, RH1 1TA
25	Grovehill House	Grovehill Road, Redhill, RH1 6TW
26	Moat House	Moat House Surgery, Worsted Green, Merstham, RH1 3PN
27	Ramsay House	Richmond Crescent, Epsom, KT19 8PH
28	Tandridge Hub	Caterham Dene, Church Road, CR3 5RA
29	The Leatherhead Institute	67 High Street, Leatherhead, KT22 8AH

Key	Clinics	Bases
North West	●	★
South West	●	★
East	●	★

In partnership with:

i-access Drug & Alcohol Services

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Health Integration and Commissioning Select Committee

SURREY

8 March 2019

Recommendations Tracker and Forward Work Programme

Purpose of report:
For Members to review and comment on the Health Integration and Commissioning Select Committee's Recommendations Tracker and Forward Work Programme.

Introduction:

A Recommendations Tracker detailing progress against actions and recommendations recorded at previous Health Integration and Commissioning Select Committee meetings is attached as **Annex 1** to this report.

A Forward Work Programme recording agenda items for consideration at future Health Integration and Commissioning Select Committee meetings is attached as **Annex 2**, and Members are asked to review the items listed on the Forward Work Programme.

Recommendations:

That the Health Integration and Commissioning Select Committee:

i. reviews progress made against actions and recommendations recorded at previous Select Committee meetings (Annex 1); and

ii. reviews items that it is due to consider at future meetings (Annex 2)

Report contact: Huma Younis, Democratic Services Officer

Contact details: 020 8541 7368, huma.younis@surreycc.gov.uk

Annexes:

Annex 1 – Health Integration and Commissioning Select Committee Recommendations Tracker

Annex 2 – Health Integration and Commissioning Select Committee Forward Work Programme

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HEALTH, INTEGRATION AND COMMISSIONING SELECT COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER – MARCH 2019

The recommendations tracker allows Committee Members to monitor responses, actions and outcomes against their recommendations or requests for further actions. The tracker is updated following each meeting. Once an action has been completed, it will be shaded out to indicate that it will be removed from the tracker at the next meeting. The next progress check will highlight to members where actions have not been dealt with.

KEY			
	No Progress Reported	Action in Progress	Action Completed

Date of meeting	Ref #	Item	Recommendations/ Actions	To	Response	Progress Check on
7 November 2018	R9/18	Working With Patients To Improve Mental Health Services: An Update On Recent Work By Healthwatch Surrey	SABP Improvement Plan in response to CQC inspection report on the Abraham Cowley Unit to be circulated to the Committee.	Surrey and Borders Partnership NHS Foundation Trust	TBC	8 March 2019

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www.surreycc.gov.uk

Health, Integration and Commissioning Select Committee
Forward Work Programme
February 2019

Health, Integration and Commissioning Committee (Chairman: Dr Zully Grant Duff, Democratic Services Officer: Huma Younis)				
Date of Meeting	**Scrutiny Topic**	**Description**	**Outcome**	**Method**
13 June 2019	Out of Hospital Care in North West Surrey	North West Surrey CCG have established a programme to review Out of Hospital Care services in their locality and are in the process of engaging with residents regarding the provision of Out of Hospital Care across Elmbridge, Runnymede, Spelthorne and Woking.	For the Committee to review the North West Surrey Out of Hospital Care Programme making recommendations.	Formal Report
Ongoing	South West London and Surrey Joint Health Overview and Scrutiny – Improving Healthcare together 2020 - 2030	In June 2017, Improving Healthcare Together 2020 - 2030 was launched, a programme led by Merton, Sutton and Surrey Downs CCGs to review the delivery of acute services at Epsom and St Helier University Hospitals NHS Trust (ESTH). ESTH serves patients from across Merton, Sutton and Surrey	A Sub-Committee of the South West London and Surrey Joint Health Overview and Scrutiny Committee has been established to scrutinise the Improving Healthcare Together 2020 – 2030 Programme as it develops.	Joint Health Overview and Scrutiny Committee

		and so the Health, Integration and Commissioning Select Committee joined colleagues from the London Borough of Merton and the London Borough of Sutton to review the Improving Healthcare Together Programme as it progresses.		
Task Groups				
January 2019 - June 2019	Mental Health	The purpose of this item is to review delivery against the Joint Health and Wellbeing Strategy's Priority to improve emotional wellbeing and mental health. This includes considering steps being taken to prevent poor mental health and to promote a culture of openness about mental health conditions. The Committee will also look at current and future provision of mental health services in Surrey.	The Committee will assess efforts to embed parity of esteem between the treatment of physical and mental health conditions in Surrey through the implementation of Sustainability and Transformation Partnerships in Surrey. Members will also look at how emotional wellbeing is incorporated within STP plans how they will help to build resilience against mental health conditions among Surrey residents.	Task Group

Health, Integration and Commissioning Select Committee

8 March 2019

Health, Integration and Commissioning Select Committee Bulletin

Purpose of report:
To update Members of the Committee on key issues relating to the delivery of healthcare services in Surrey and detailing work underway to scrutinise these.

Introduction:

1. Annex 1 to this report contains a short bulletin outlining some key issues taking within healthcare delivery in Surrey as well as actions underway or plans to scrutinise these by the Committee.

Report contact: Huma Younis, Democratic Services Officer

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Annexes:

Annex 1 – Health Integration and Commissioning Select Committee Bulletin

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Annex 1

Health Integration and Commissioning Select Committee Bulletin – February 2019

'This bulletin relates to the major NHS programmes currently affecting Surrey and includes a summary update on my activities as a member of external scrutiny committees in the last quarter, pointers to further information and recent Health news'

Thank you,

Dr Zully Grant-Duff
Chairman, Health Integration and Commissioning Select Committee

Major Acute Services at Epsom and St Helier University Hospitals Trust

The Improving Healthcare Together Programme

Improving Healthcare Together 2020 – 2030 is programme run collaboratively by Merton, Surrey Downs and Sutton Clinical Commissioning Groups to review the sustainability of major acute services at Epsom and St Helier University Hospitals NHS Trust. Specifically, the programme is considering options for locating these services on a single site; either Epsom Hospital, St Helier Hospital or Sutton Hospital. Find out more about the programme here: https://improvinghealthcaretogether.org.uk/

Scrutiny of the Programme

Scrutiny of the Programme is being conducted by a Sub-Committee of the South West London and Surrey Joint Health Overview and Scrutiny Committee comprised of the Health Overview and Scrutiny Committee Chairmen from the London Borough of Merton, the London Borough of Sutton and Surrey County Council. The Sub-Committee meets monthly to keep pace with the Programme and meetings are held across the three local authority areas to ensure accessibility for residents who could be impacted by the proposals.

The Sub-Committee recent meetings took place on 28th November 2018 and 7th February 2019 when the focus of scrutiny has been public engagement sessions in relation to the Options Consideration Process. For agenda papers and dates for

Sussex and East Surrey STP

Sussex and East Surrey Sustainability and Transformation Partnership

Sussex and East Surrey is a sizeable STP encompassing a population of 1.8 million people, 185,000 reside in the Reigate and Banstead and Tandridge areas of Surrey. Alongside the East Surrey area, the STP also incorporates the areas of East and West Sussex County Council and Brighton and Hove City Council. The STP is facing some significant challenges arising from the complexities of its geography, the number of organisations involved in the STP and the financial challenges facing the health and social care system across the footprint area. Find out more about Sussex and East Surrey STP here: http://www.seshealthandcare.org.uk/

Scrutiny of Sussex and East Surrey STP

The Chairmen of the Health Overview and Scrutiny Committees across the local authorities in the footprint meet regularly with NHS officers to discuss proposals and review progress on aspects of the STP ranging from finances, governance and the formation of Central Sussex and East Surrey Commissioning Alliance (CSESCA). CSESCA has recently launched its Clinically Effective Commissioning (CEC) Programme to review clinical interventions commissioned by CCGs to standardise these across the Alliance.
There has been a significant delay in the CEC Programme and consequently the formal establishment of a Joint Health Overview and Scrutiny Committee to scrutinise the Programme has been postponed. To find out more about the CEC Programme

upcoming meetings follow: https://mycouncil.surreycc.gov.uk/ieListMeetings.aspx?CId=759&Year=0	follow: https://www.brightonandhoveccg.nhs.uk/our-programmes/clinically-effective-commissioning
Out of Hospital Care in North West Surrey **What is the Big Picture Programme** North West Surrey CCG are in the process of engaging with residents regarding the provision of Out of Hospital Care across Elmbridge, Runnymede, Spelthorne and Woking. Residents are being asked to contribute their views on how care should be delivered outside of the main hospitals, the implementation of Urgent Treatment Centres as well as services that should be provided through the rebuilt Weybridge Hospital. A number of events have been held throughout the CCG area in order to engage with residents. To find out more about the programme follow: http://www.nwsurreyccg.nhs.uk/get-involved/consultation-and-engagement/the-big-picture **Scrutiny of the Big Picture Programme** The Chairman and Vice-Chairman of the Health Integration and Commissioning Select Committee met with officers from North West Surrey CCG for an update on the engagement process and the list of options being considered. Further discussions will take place, which we anticipate will also include a workshop with the whole committee, once a set of proposals has been developed to determine whether these constitute substantial variation.	**Ashford & St Peter's Hospital** **Reconfiguration of Vascular Services to National Standards** The Chairman of the Health Integration and Commissioning Select Committee met with senior representatives of North West Surrey CCG and NHS England Specialised Commissioning for a briefing and discussion on impending reconfiguration plans. National commissioning standards and deliverables for vascular services require these services to have a certain level of activity to enable consultant emergency 24/7 on-call cover for faster treatment with improved patient outcomes. The national standard defines only two service models, (1) all vascular services delivered in a single centre serving a population of 800,000, or (2) a hub and spoke network model between providers. Serving a population of approximately 400,000 in NW Surrey means ASPH can no longer be commissioned as a stand-alone service. **Scrutiny of the ASPH Reconfiguration of Vascular Services** A briefing paper has been prepared for the South West London and Surrey Joint Health Overview and Scrutiny Committee, on the development of a revised service model for vascular services at St Peter's Hospital relating to plans to establish a nationally mandated Vascular Network and to engage with local people on proposed plans. Essentially local services are being reorganised to create a vascular network across three Foundation Trusts in the South West London and Surrey area.

Health, Integration and Commissioning Select Committee

8 March 2019

Mapping the Patient's Journey through Adult Mental Health Services in Surrey- Task and Finish Group Scoping Document

Purpose of report: For the Select Committee to review the attached scoping document.

Introduction:

1. The Chairman of the Health, Integration and Commissioning Select Committee joined the members of the Task Group at their meeting to agree the scoping document attached in Annex 1.

2. Following discussions with the Chairman and Vice-Chairman of the Children and Education Select Committee it has been agreed that the scrutiny of the Children and Adolescent Mental Health Services (CAMHS) and the re-commissioning of the CAMHS contract will be done primarily by the Children and Education Select Committee and so will be out of scope for the Task Group. The re-design and co-design of CAMHS has already commenced with a series of workshops held by SCC and Surrey's CCGs for children, young people, parents, carers and all those who work with children and young people in various roles and professions.

Recommendations:

For the Select Committee to review the task group scoping document providing comments as necessary.

Report contact:
Huma Younis, Democratic Services Officer
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Sources/background papers:
Annex 1 – Mapping the Patient's Journey through Adult Mental Health Services in Surrey- Task and Finish Group Scoping Document

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SURREY

Annex 1- Select Committee Task and Finish Group Scoping Document

The process for establishing a task and finish group is:

1. The Select Committee identifies a potential topic for a task and finish group
2. The Select Committee Chairman and the Democratic Services Officer complete the scoping template.
3. The Corporate Services Select Committee reviews the scoping document
4. The Select Committee agrees the membership of the task and finish group.

Review Topic: Mapping the Patient's Journey through Adult Mental Health Services in Surrey
Select Committee(s) Health Integration and Commissioning Select Committee
Relevant background The increase in people experiencing mental health problems represents a growing challenge for the UK. Research suggests that approximately a quarter of the population will experience a mental health condition each year. In Surrey, with a population of 1.2 million, 300,000 people, three times the number of people as live in Surrey's largest conurbation, Woking, will experience mental illness each year. Nationally, the most common types of mental health conditions experienced are generalised anxiety disorder (5.9 in 100 people), depression (3.3 in 100 people) and post-traumatic stress disorder (4.4 in 100 people). More complex mental health conditions are also prevalent such as bipolar disorder (2.0 in 100 people) and psychotic disorders (0.7 in 100 people). Mapping these statistics against Surrey's population demonstrates the size of the challenge that the county faces. The length of time that many people are required to wait for treatment for a mental health condition suggests that services across the country are under immense strain. Indeed the Health Integration and Commissioning Select Committee has heard first-hand of the pressure on mental health services in Surrey from the county's mental health provider, Surrey and Borders Partnership NHS Foundation Trust (SaBP), who stated that their inpatient services are operating at over 100% capacity. But the impact of mental health conditions ripple across the wider public sector putting additional pressure on services that are already struggling to keep pace with demand. Ambulance trusts, acute trusts, GPs, the Police and Prison Service are all experiencing significant challenges arising from growing prevalence and awareness of mental health and the damage that it causes. The most significant impact, however, is on those who experience mental illness, the implications of which can be severe. Research has shown that 6.7 out of every 100 people in the UK will attempt suicide in their lifetime while 7.3 out every 100 people will self-harm. Evidence also indicates that the link between mental and physical health contributes significantly to the burden of disease meaning that

people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people, one of the greatest health inequalities in England. Mental health conditions unite all areas of the population irrespective of geography, gender, race or age but there is evidence to suggest that those from poorer backgrounds are at increased risk of developing a mental health condition across their lifetime.

Through publication of its Mental Health Five Year Forward View, NHS England has committed to embedding parity of esteem between mental and physical health which it has supported with additional resource and funding to improve the accessibility and quality of mental health provision. Increased recognition of mental health and the challenges it presents is to be welcomed but there must also be recognition of a patient's journey from development and diagnosis of a mental illness to treatment for that condition which takes account of the many other services that they may come into contact with before, during and after treatment. Introducing a holistic approach to supporting people with mental health conditions and understanding how they interact with the public sector at different times is the most effective means of improving outcomes for patients and supporting them in having full and fulfilling lives.

At its meeting on 7 November 2018, the Health Integration and Commissioning Select Committee considered the outcomes of an Enter and View Report by Healthwatch Surrey on the Abraham Cowley Unit, an inpatient mental health ward operated by SaBP, which highlighted specific challenges around the delivery of inpatient mental health services in Surrey. As part of these discussions, Committee Members reflected on how national challenges relating to the treatment of mental health were manifesting themselves in Surrey and on the provision of services locally. It was recognised that more in depth consideration was required into how the public sector across Surrey supports people through mental illness to reduce demand on services and ensure the best outcomes for residents in response to the growing burden of mental illness in the County.

Why this is a scrutiny item

Scrutiny can take an elevated view of mental health services and support in Surrey by considering individual experiences of those who develop a mental health condition and their interactions with different agencies as they journey through the system. Looking holistically at the many services and sectors that support recovery from a mental health condition from the standpoint of patients is a perspective that only the Select Committee can offer. Considering these many interconnecting services collectively from the patient perspective will foster improved understanding of how public sector organisations in Surrey can work together more effectively to improve outcomes for residents. Scrutiny can also support the health and social care system to identify any gaps in support as well as highlighting those interventions or services that work well.

Provision of mental health services has been identified as a key priority for residents by Healthwatch Surrey. This accords with growing recognition of the burden of mental illness in the UK and the strain that it places on individuals, families and communities. The Select Committee has a duty to listen to residents on the issues that it considers and to ensure that the provision of healthcare services in Surrey reflect the voice of residents. Given the importance of mental health to residents, the Select Committee wishes to ensure that their concerns about the quality and accessibility of mental health services are being listened to and understood in the delivery of mental health services.

Projections suggest that around a quarter of people in Surrey (300,000 residents) will experience mental illness each year. Even more alarmingly, 82,800 residents will attempt suicide in their lifetime and 87,600 will self-harm. There can be few issues that have such a significant impact on so many residents as mental health not to mention the wider affects that it has on families and communities. The Select Committee must prioritise its work towards those areas where it can have the greatest impact. By reviewing how those with mental illness are supported in Surrey the Select Committee has the potential to make recommendations on how to improve services for a significant portion of residents.

Surrey County Council has recently published its ‘Community Vision for Surrey in 2030’ which highlights the importance of having public sector services that support people to live full and fulfilling lives. Reducing the burden of mental illness will be a critical component of delivering against this vision given that it affects a quarter of Surrey residents each year and will require a unified approach across all organisations that deliver services across the county. Prevention and early intervention will play an important role in reducing the burden of disease arising from mental health conditions, scrutiny can support the health and social care system in Surrey to understand how it can promote emotional wellbeing among its residents,

There are a variety of strategies which govern how public sector organisations in Surrey aim to address the challenges arising from mental illness ranging from the Promoting Emotional Wellbeing and Mental Health Priority within Surrey’s Joint Strategic Needs Assessment to the County’s Suicide Prevention Plan. The Select Committee can utilise its unique role within the health and social care system to review the interactions and gaps between these different strategies and support services to collaborate as effectively as possible.

What question is the task group aiming to answer?

What is the journey through the system for adults who require support for a mental health condition in Surrey and what are their experience of using outreach, community and inpatient mental health services?

How effective are public sector organisations in Surrey at preventing the development of mental health conditions or at identifying and intervening at an early stage where prevention has not be possible to improve outcomes for residents and reduce demand on acute mental health services?

What services are those with mental health conditions most likely to come into contact with and how are these services equipped to provide effective support?

Is adult mental health treatment and support in Surrey person-centred and do patients feel involved in their care plans?

How do patients' stories align with local data and national best practice on treatment for those with different types of Mental Health conditions and what conclusions can be drawn about whether public sector organisations in Surrey support people with mental health conditions to live full and fulfilling lives in accordance with the 'Community Vision for Surrey in 2030'?

Does Surrey take an integrated approach to the treatment of mental and physical health?

What constitutes parity of esteem between the treatment of physical and mental health and has this been achieved in Surrey?

Aim

For Members of the Task Group to understand the patient journey through the adult mental health system in Surrey to consider how organisations across the public sector are working together to support those with mental health conditions to live full and fulfilling lives. The Task Group will focus its review on adult mental health services in Surrey while recognising that mental health problems often begin in childhood.

Objectives

- review the journey of adults with mental health conditions in Surrey through support services and interventions to assess how their interactions with different public sector organisations aid their recovery.

- define what constitutes parity of esteem between the treatment of physical and mental health and whether this exists in Surrey; and

- assess whether there is integration in the treatment of patients' physical and mental health.

Scope (within / out of)

In Scope

- adult mental health inpatient, community and outreach services in Surrey;
- GP referral process and waiting times for treatment;
- mental health crisis support;
- parity of esteem between physical and mental health;
- suicide prevention;
- Promoting Emotional Wellbeing and Mental Health Joint Health and Wellbeing Strategy Priority; and
- agencies in frequent contact with those with mental health conditions including acute trusts, ambulance trusts and the Police.

Out of Scope

- Children and Adolescent Mental Health Services (CAMHS)
- Recommissioning of the CAMHS contract

Outcomes for Surrey / Benefits

contribute to the reduction of health inequalities for those with severe and prolonged mental health conditions;

help to embed a patient-centred approach to mental health support in Surrey that incorporates and understands the role of the whole system;

support the health and social care system in embedding parity of esteem between mental and physical health;

create a shared understanding of patients' journey through the mental health system in Surrey; and

reduce the stigma around mental health in Surrey and raise the profile of support services available.

take an elevated view of mental health services and support in Surrey by considering individual experiences of those who develop a mental health condition and their interactions with different agencies as they journey through the system

Proposed work plan

It is important to clearly allocate who is responsible for the work, to ensure that Members and officers can plan the resources needed to support the task group.

Timescale	Task	Responsible
January 2019	Hold workshop with Task Group Members to define scope, work plan and desired outcomes.	
January – February 2019	Build case studies about the experience of mental health service users across outreach, community and inpatient services as well as across the different segments of the population.	

January/ February 2019	Meet with representatives from Surrey and Borders Partnership to understand pathways to care for those with mental health conditions.	
March – May 2019	Meet with agencies to compare case studies against policies and protocols of different agencies mentioned within the case studies.	
May 2019	Hold workshop with Task Group Members to identify areas for recommendation.	
June 2019	Compile report.	

Witnesses

Mental Health Service Users (x10)

Mental Health Service Users' families

GPs

Surrey and Borders Partnership NHS Foundation Trust

Improving Access to Psychological Therapies (IAPT) Practitioners

Clinical Commissioning Groups

Mental Health Charities such as the Samaritans and MIND

Potential Witnesses

South East Coast Ambulance Service (SECAmb)

Surrey's acute trusts

Surrey County Council Public Health Team

Surrey Police

Health and Wellbeing Board

Voluntary Sector Organisations

Housing providers

District and Borough Councils

Useful Documents Mental Health Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Independent Review of the Mental Health Act https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
Potential barriers to success (Risks / Dependencies) Lack of willingness to engage by past or present users of mental health services Lack of willingness to engage from agencies that aren't statutorily required to provide evidence to the Committee. Criticism arising from focusing on qualitative research based on the experience of a few service users rather than using quantitative research.
Equalities implications

Task Group Members	Nick Darby Fiona White Bill Chapman David Wright
Co-opted Members	None
Spokesman for the Group	Nick Darby
Democratic Services Officer/s	TBC

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