5 Year Strategic Delivery Plan 2019 - 2024

A Partnership approach to transforming local health and care services

Surrey Heartlands

HEALTH AND CARE PARTNERSHIP

V0.12 for submission
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Please Note: Purdah activation influenced the final approval date.				
Please see appendix 1 for Approvals Timeline				
Quality and Equality Impact Assessments are undertaken by work programmes and organisations. Through the development of this delivery plan, colleagues provided an assessment status against work areas. **Reported position** 98% In progress 0% No major change to the service required 2% Adjusted the service to remove barriers identified 0% Continue the service despite potential for negative impact				

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Foreword

Surrey Heartlands Health and Care Partnership has been working as an Integrated Care System (ICS) since 2017. We have moved away from an individual organisational focus to creating partnerships with shared commitments and visions that will improve the lives of local people. We have had some successes: the quality of care in 100% of our NHS Trusts, 99% of GP surgeries and 83% of care homes is rated 'good' or 'outstanding' by the Care Quality Commission (CQC); we have achieved a system financial balance for the last two years; over winter we have were delivered able to offer 97,000 more GP appointments (18,000 by video consultation); we have secured £8m of extra funding for mental health services within primary care and our acute hospitals; and we now have some of the best rates nationally for the early diagnosis of cancer.

But there is still lots more to do.

We have always worked closely with colleagues in Sussex, Frimley Health ICS and South West London, as many people that live in Surrey Heartlands receive healthcare from neighbouring health and care providers and we are really pleased to be working even closer with colleagues from East Surrey as they formally join Surrey Heartlands ICS.

The priorities set out in the NHS Long-term Plan align well with the ambitions of our system and will help us go further faster. However, we know that 80% of the factors that determine good health are not within the control of the NHS and care services. The neighbourhood you grow up in, your home, family and people around you, your schooling, job opportunities and lifestyle choices – all have more impact. The work we have done together to create the Surrey 10 year Health and Wellbeing Strategy focuses on these wider determinants of health and prevention, targeting our populations who do less well. Our focus on the first 1,000 days of a child's life is to ensure that every child has the best start, enabling them to enjoy a healthy life where they feel safe, confident and are able to fulfil their bringing generational change for our population.

We will continue to maximise efficiencies through working together in a more joined up way, and we also need to work closely with our citizens, moving towards a culture where new ideas, technologies and innovations are at the heart of our transformation. Greater local control provided through devolution will help us improve health and care outcomes through multi-sector partnerships, such as education, housing and the environment. With the development of our Integrated Care Partnerships and Primary Care Networks, we can also make sure that we do not lose sight of local need, and can provide evidence-based models of care, based on what our local population needs, and supported by multi-disciplinary teams.

Surrey is the most densely populated Shire County with a high cost of living and close proximity to London, leading to complex workforce problems. But our most senior leadership does not reflect the diversity of our workforce or population. Our workforce strategy has a particular focus on improving inclusion, retention and developing our people.

It is with shared experience and ownership, and a strong foundation that we aim for our plans to result in a financially sustainable, integrated care system that maximises our freedoms under devolution and delivers our strategic priorities for the benefit of local people, making Surrey Heartlands the best place to live and work.

Dr Claire Fuller
Senior Responsible Officer

Executive Summary

A whole system approach

Surrey Heartlands represents 85% of the Surrey population, with a combined health revenue allocation of over £1.5bn and combined social care and public health budget of £317m.

We are proud of our achievements since Surrey Heartlands' formation in 2016. We are one of the country's first wave of Integrated Care Systems and were only the second to agree a devolution deal. We have focussed on **creating health and care partnerships that work better for the people we serve**. This includes the establishment of four geographical Integrated Care Partnerships and 24 Primary Care Networks as the key front line partnerships delivering care.

A Vision for Surrey

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.

Through unprecedented collaboration, we have an agreed **10 year Health and Wellbeing Strategy, which** recognises and seeks to address the wider determinants of health. We know that clinical intervention or treatment contributes only **20%** to an individual's health outcome. Our strategy sets out three interconnected priorities:

- Leading health lives
- Having good mental health and emotional wellbeing
- Fulfilling potential

We are using the life phases of 'Start Well', 'Live Well' and 'Age Well' as a framework to drive generational and sustainable long-term change. These improvements can't be done alone. We are working with all our partners, including districts and boroughs, voluntary, faith and community sectors in a population health approach to optimise physical and mental health outcomes and reduce inequalities and unwarranted variation.

Developing our Integrated Care System

Surrey Heartlands became a Wave 1 Integrated Care System (ICS) in 2017. We are working in a new way with local health and care partners and regulators to make decisions about how we use our collective resources to meet standards and improve the health outcomes of the people we serve. Our ICS is based on the key principles of improving population health outcomes through **subsidiarity** and **integration**. From 2019, we have adopted a System-led approach to assurance.

We continue to develop our integration model with Surrey County Council, through Surrey Wide Integrated Care partnership, focused on areas including Children's and Mental Health services. We already have a number of joint posts with the Council and in the next few years we will use both the flexibilities of devolution and section 75 agreements to create a fully integrated leadership model. We will have appointed to System wide Joint Executive Leadership posts for Digital, Mental Health, Children, Estates and will explore further opportunities.

Our **devolution status** has given us an opportunity to take a more explicit role in the development of specialised services, immunisation and some elements of dental services. These will continue to be expanded to further support the broader concept of capitated budgets. The immediate priority for devolution is to use our unique relationship with Surrey County Council and district and borough councils to take more direct control and influence of our NHS property portfolio.

Our ambition to support people in Surrey to live longer healthier lives ultimately requires a shift to a preventative approach, addressing root causes of poor health and wellbeing. **Recent signals about a**

renewed commitment in central government to promote devolution to local areas represent a compelling opportunity to accelerate the achievement of this ambition. Our first devolution agreement, signed in 2017, focused on greater local control of health and care commissioning decisions and closer alignment of the commissioning responsibilities of the NHS and local government. **The next stage is to achieve even greater integration of services extending beyond health and social care to include public health, housing, employment and other local services that function as the wider determinants of health.** Proposals are currently being developed around the devolution of NHS estates in Surrey as part of ambitions to secure the maximum value from the local public sector estate and, through it, the ability to create a local transformation fund that would enable us to support improved outcomes for residents on a financially sustainable basis.

This report outlines our ambitions to improve care for our local population and outlines a commitment to deliver on the key elements of the national long term plan.

A new service model for the 21st Century

Our new service model is based on boosting 'out-of-hospital' care and using our Primary Care Networks as the foundation for delivering integrated services in neighbourhood networks.

By 2021, there will be parity of community health crisis response within 2 hours of referral and reablement care within 2 days of referral, where needed, across Surrey Heartlands. Our System is already successfully **delivering General Practice Improved Access (GPIA) to 100% of our population, 7 days a week**. By 2021, citizens can expect access to primary care services between 8am and 8pm across Surrey Heartlands, with the option of digital access to primary care, including video consultations.

By March 2024, our ambition is that Primary Care Networks (PCNs) will have stabilised the GP partnership model, become a proven platform for further local NHS investment, including premises. PCNs do not have hard boundaries which provides flexibility in the way they work within local communities. By 2021, there will be **39 trained social prescribing link workers**, rising to **83** by 23/34, with the aim of **supporting over 17,000 people**. Surrey Heartlands will, as a minimum, **more than double** the use of **Personal Health Budgets by 2023/24.**

Through our **new models of care for out-patient services are** designed to meet local needs and contribute to the strategic goals of the ICS. By March 2024 we will be deploying digital solutions at scale, further enabling our population to access health and care closer to home. **We aim to reduce face to face contacts by 70%.** Outpatient attendances, where required, will provide the highest quality care. Our citizens and care professionals will be digitally connected.

Prevention and Health Inequalities

Enabling people in Surrey to lead healthy lives means not just addressing individual **lifestyle factors**, smoking, harmful drinking, excess weight, but also the **environment** in which they live. Our expected outcomes[1] from the Health and Wellbeing strategic priorities include:

- People have a healthy weight and are active. We plan to increase citizens' use of outdoor space for exercise from our **current rate of 20.5% to a 'best in class' rate of 24.4%**.
- Reducing smoking rates among adults employed in routine and manual occupations **from 21.5% to a 'best in class' rate of 11% for this population**.
- Everyone lives in adequate housing**.** For people with a learning disability and/or autism, we want to move from our **current position of 66%** of this population to **87% living in settled accommodation**.

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[1] These and other prevention related targets referenced in this plan are subject to discussion and approval at December 2019 health and wellbeing board.

- Prevention of disease through vaccination and early diagnosis. We will **increase the coverage of MMR vaccinations** from our current rate of 81.7% **to 93.8%.**
- People are supported to live independently for as long as possible. We aim to increase the percentage of older people still at home 91 days after discharge from hospital from our **current rate of 69.8% to 93%**.

We recognise that the majority of care in Surrey is provided by family and friends. We will ensure that **carers** are respected, recognised, valued and supported both in their caring role and as individuals. Our ambition is to **increase health checks for carers by 11% annually to achieve 3,050 by 2024 and to increase the number of flu vaccinations given to carers to 13,000 by 2024.**

Progressing Care Quality and Outcomes

By enabling **quality to lead change and add value**, we have adopted a quality management System approach to help effectively manage quality. It brings together the four key principles of assurance, control, planning and improvement and allows organisations and partnerships to gain confidence, knowing they have a robust cycle of managing and improving quality.

All of Surrey Heartlands NHS provider trusts are rated '**good'** or '**outstanding'** by the Care Quality Commission (CQC). **83% Adult social care** services are rated '**good'** or '**outstanding'**. This includes a rating of 'good' or 'outstanding' for 71% of nursing homes, 86% of residential homes and 68% of domiciliary care. **All** GP Practices are rated 'good' or 'outstanding'. This means that **100% of our 24 Primary Care Networks are providing 'good' or 'outstanding' care overall.**

We will continue to improve the quality of our care. The Surrey Heartlands Academy supports health and care practitioners to adopt, share and evaluate innovations, research and best practice.

In delivering our aspiration to achieve generational change, our focus on the **First 1,000 days** recognises the importance of a strong start to improve a child's life chances. **We aim to increase the percentage of children in care achieving 5A*- C or equivalent GCSEs to increase from the current rate of 17.2% to the 'best in class' rate of 23.9% over the next 10 years.** We continue to develop and transform our care for major health conditions, with a strong focus on integrating physical and mental health services and support.

By 2024, we will have **increased** our one-year **survival from cancer rates from 73.8% to 80%**.

Having already **met the national target of 34%** for Child and Adolescent Mental Health Service (CAMHS) access, we aim to achieve 38% by 2022/23. **Our ambition is to reduce our average waiting time for CAMHS by at least a week each year to move closer to the NHS Long Term Plan ambition of 4 week waiting times for CAMHS.** We will **increase the uptake of annual health checks for people with learning disabilities from 45% to 75%.**

We will accelerate work to **reduce length of stay** in adult acute mental health units to the national average of **32 days**. The elimination of out of area placements (OAPs) within this strategic period is reliant on our capital programme.

As a System, Surrey Heartlands continues to work to meet its **constitutional targets** and will deliver this through an elective care transformation programme. A number of projects are in place under this programme of work that will ensure:

- commissioning and provider organisations are working together to implement the choice process for all patients who reach a 26-week wait
- providers are able to deliver the 1% diagnostic target[2]

Our plan confirms **delivery** of 97% the NHS LTP performance metrics:

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[2] Diagnostic waiting time operational standard where less than 1% of patients should be waiting six weeks or longer

Code / RAG	Programme Area	Name
E.D.16	Primary Care	Proportion of the population with access to online consultations
E.D.20	Digital	Citizen facing tools: Proportion of the population registered to use NHSApp
E.D.21	Digital	Cyber Security (CCG)
E.D.21	Digital	Cyber Security (Provider)
E.A.3	Mental Health	IAPT roll-out
E.H.9	Mental Health	Improve access to Children and Young People's Mental Health Services (CYPMH)
E.H.12a	Mental Health	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
E.H.12b	Mental Health	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
E.H.13	Mental Health	People with severe mental illness receiving a full annual physical health check and follow up interventions
E.H.15	Mental Health	Perinatal Mental Health: Number of women accessing specialist perinatal mental health service
E.H.16	Mental Health	Mental Health Liaison services within general hospitals meeting the "core 24" service standard
E.H.17	Mental Health	Number of people accessing Individual Placement and Support
E.H.18	Mental Health	EIP Services achieving Level 3 NICE concordance
E.H.19	Mental Health	Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness
E.H.20	Mental Health	Coverage of 24/7 crisis provision for children and young people that combine crisis assessment, brief response and intensive home treatment functions.
E.K.1a	LD	Reliance on inpatient care for people with a learning disability and/or autism - adults - CCG Commissioned
E.K.1b	LD	Reliance on inpatient care for people with a learning disability and/or autism - adults - Spec Com
E.K.1c	LD	Reliance on inpatient care for people with a learning disability and/or autism - adults - total
E.K.3	LD	Learning Disability Registers and Annual Health Checks delivered by GPs
E.M.23	UEC	Ambulance Conveyance to ED
E.M.24	UEC	Delayed Transfers of Care
E.M.25	UEC	Length of stay for patients in hospital for over 21 days
E.N.1	Personalised Care	Personal Health Budgets
E.N.2a	Personalised Care	PCN Network Contract DES Funded Social Prescribing Link Workers
E.N.2b	Personalised Care	CCG Funded Social Prescribing Link Workers
E.N.2c	Personalised Care	Number of social prescribing referrals
E.N.3	Personalised Care	Personalised Care and Support Planning
E.P.1	Cancer	One Year Survival from Cancer
E.P.2	Cancer	Proportion of cancers diagnosed at stages 1 or 2
E.Q.1	Maternity	Stillbirth rate
E.Q.2	Maternity	Neonatal mortality rate
E.Q.3	Maternity	Percentage of women placed on a continuity of care pathway
E.Q.4	Maternity	Brain Injury Rate
E.R.1	Diabetes	Number of people supported through the NHS Diabetes Prevention programme
E.S.1	Stroke	Proportion of patients directly admitted to a stroke unit within 4 hours of clock start
E.S.2	Stroke	Percentage of applicable patients who are assessed at 6 months

Supporting our Workforce

Our vision is to have the right team, with the right tools and skills, providing care in the right place and at the right time, to meet the needs of our population. Living in Surrey has many benefits, but a relatively high cost of living and proximity to London (with higher London weighting) presents challenges for recruitment and retention of staff. We want to make Surrey Heartlands recognised as the 'Best Place to Work', to attract and retain staff from all professional groups. To achieve this, we need to promote equal opportunities to all. We will monitor our progress by utilising the results from the staff surveys, reporting openly on our % of staff from protected characteristics.

We are launching our Equality, Diversity and Inclusion Strategy in early 2020, this is to provide a clear agenda for Surrey heartlands to promote Equality, Diversity and Inclusion (EDI) across our 'one team' ethos.

Through our 'Surrey 500' Surrey Heartlands' first large-scale leadership programme - we are offering the opportunity for individuals to learn with colleagues from across the System and focusing on Systems leadership, rather than the traditional theories of management and leadership.

We will explore workforce redesign options, in developing and utilising the workforce in different ways. We will work with Health Education England (HEE) using the 5 workforce enablers of the HEE STAR. Staff are our most important resource. We recognise that we must develop and support our workforce in order to deliver our ambition for service delivery and service transformation.

Digitally enabled care

By March 2024, there will be comprehensive digitalisation across the System with locally shared records supporting high quality care. We will have a digitally skilled workforce, with centrally delivered capabilities enabling new service models. Citizens will have digital care plans and personal health records and be involved in co-designing to ensure digital designs and solutions are safe, ethical and effective.

Taxpayers' Investment will be used to maximum effect

Historically, the organisations within the Surrey Heartlands system have collectively met financial targets delivering the system Control Total in 2017/18 and 2018/19 although has relied on non-recurrent measures. The expected improvement in the system control total in 2019/20 is again proving a challenge (the 2019/20 plans now include East Surrey and SASH) and further non recurrent measures are being explored. The assessment of the opening position for 2020/21 is a £62.4m deficit (excluding incentives).

The ICS is committed to resolving the underlying position and addressing some of the embedded structural financial issues through the transformation of services outlined in the 5 year plan and the 10 year strategy. **The modelling outlines a reduction from a £62.4m deficit (excluding incentives) in 2020/21 to £10.4m deficit (excluding incentives) in 2023/24.** This represents a £40.5m gap to trajectories in 2020/21 reducing to meet the trajectory at the end of the period (including incentives) which reflects a significant reduction in costs across the 4 years. These plans assume that Surrey Heartlands ICs will receive the £25m of local devolution transformation funding in 2020/21.

		Total ICS			
£m	**FOT 19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Surplus / (Deficit) (including incentives)	**5.6**	**(50.1)**	**(31.8)**	**(6.9)**	**2.7**
Surplus / (Deficit) (excluding incentives)	**(27.9)**	**(62.4)**	**(44.4)**	**(19.8)**	**(10.4)**
System Trajectory*	(1.5)	(9.5)	(3.7)	0.6	2.7
Gap to system Trajectory	7.1	(40.5)	(28.1)	(7.5)	(0.0)
System Efficiencies					
Savings in plan - Commissioner 1%	36.9	14.2	14.8	15.3	15.8
Savings in plan - Recurrent	29.9	27.2	24.6	26.7	27.1
Savings in plan - Non Recurrent	9.2	6.0	6.2	6.4	6.5
Savings in plan - Other	32.0	0.0	0.0	0.0	0.0
Total Savings in plan	**107.9**	**47.5**	**45.5**	**48.4**	**49.4**
Savings %		**1.5%**	**1.4%**	**1.4%**	**1.4%**

This recovery plan will build upon the 2019/20 Financial Recovery Plans that have been developed. Whilst it is acknowledged that this is a start, these plans need to be progressed to cover the 5 year planning period and to determine how jointly the system can reduce real costs across all organisations in line with the system transformation outline throughout these plans. This work is already in progress with local ICPs and a system wide services review covering all areas that impact on the system. We are building on the 2019/20 work to develop explicit System Recovery Boards with multi-year recovery plans for our ICPs that our projecting deficit positions. This process has been agreed between Surrey Heartlands and Sussex for the East Surrey ICP and with South West London for the Surrey Downs ICP.

Chapter 1: A whole System Approach

We are proud of our achievements since the formation of the Surrey Heartlands' in 2016. We are one of the country's first wave of Integrated Care Systems and were only the second to agree a devolution deal. We have focussed on creating health and care partnerships that work better for the people we serve. This includes the establishment of four Integrated Care Partnerships and 24 Primary Care Networks as the key front line partnerships delivering care. Some other examples of what we have done include:

Setting up an award winning **24/7 Maternity Advice line** with midwives co-located at our ambulance call centre. This has had positive impact on ambulance call out rates, the pressure on our maternity wards/clinics and most importantly pregnant women feeling supported,

Transforming diabetes care services – including new diabetes specialist nurses at our hospitals and in the

Collaborative teams across health and adult social care to improve hospital discharge – for example, *Home First* at Royal Surrey County Hospital.

Piloted **online GP consultations** allowing patients to speak to GPs who can provide medical advice, prescriptions, fit notes and referrals to help relieve pressure on local GP practices.

Research using technology – our award-winning TIMH for Dementia study uses cutting edge technology to improve the quality of life for people with dementia living at home

Increased access in primary care across Surrey Heartlands through the **Extended Access Service**, providing more GP and nurse appointments during the evenings and at the weekend.

Creating children & families hubs with collocated developmental, mental health and health, social care teams

Developing integrated mental health within our primary care networks

Technology: paediatric HANDI App rolled out providing advice and support to parents/ carers if their children have symptoms of common childhood illness. 93% of those using the app would recommend it.

Academy focus, with the Academic Health Science Network on cardiovascular prevention - in particular to detect and treat hypertension and atrial fibrillation, both major contributors to strokes and heart attacks.

Success pilot of **musculoskeletal tool to support GPs** in decision making and offering self-help advice to patients – roll out across Surrey Heartlands in 2019.

Established **CORE 24** in Ashford St. Peters and Royal Surrey County Hospitals to improve integration of physical and mental health

Established a perinatal **mental health service – autumn 2018**

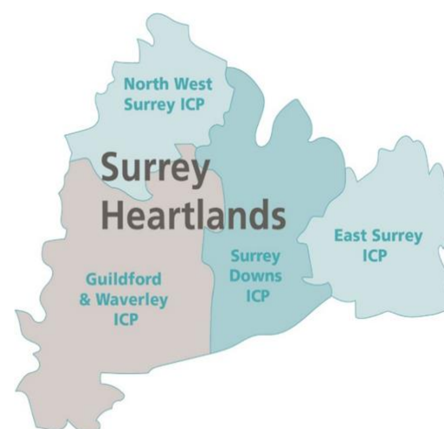
Developed a single point of access for mental health crisis and is being rolled out across the footprint

Digital access to health records: Surrey Care Record went live 2018 sharing of GP records with A&E

Secured £4m of capital funding to develop mental **health community hubs -** bringing services closer to our residents.

A picture of Surrey Heartlands

Surrey Heartlands Health and Care Partnership (SHHCP) serves over 1 million people within the areas of East Surrey, Guildford and Waverley, North West Surrey and Surrey Downs and accounts for over 85% of the overall Surrey population. Surrey Heartlands has a combined health revenue allocation of over £1.5bn and combined social care and public health budget of £317m.



We have used the Surrey Joint Strategic Needs Assessment and the Health and Care Profiles produced by Pubic Health England to help identify the areas of need for our population and focus discussion with clinical leads, stakeholders and citizens on matters of concern. 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.

Surrey shares many of the same challenges as other areas across the UK; an ageing population with increasingly complex needs, increasing demand on services for vulnerable children and significant pressure on public finances. The economic success of Surrey as a county means that it makes a significant contribution to the UK economy and whilst overall Surrey has a relatively healthy population, this masks significant gaps and inequalities that exist.

The county 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. Compared to the national distribution, Surrey Heartlands has a much larger population aged between 40 and 60 and those aged over 85 years. Over the next 10 years, the population of over 65 years, will increase by 20%. By 2029, almost 60% of our population will be working age and 22% will be over 65 years.

The populations of our ICPs have a life expectancy[3] is better than the England average of 79.2 years for males and 82.9 years for females. We range from 80.6 years in East Surrey and North West Surrey to 82.6 years in Guildford and Waverly for men and 83.9 years to 85.1 years for women. Whilst this is positive, the increasing complex needs of citizens means that around 84% of lives are lived in ''good health' which equates to around 10 years of life requiring increasing support. The health conditions where the most 'potential years of life lost' is most significant are cancer, heart disease and respiratory, however for all conditions they are much lower than that seen nationally (England).

We have 30% of adults living with at least one long term condition and one in ten citizens are carers. Around 42% of young people are unpaid carers and 54% are aged between 18 and 64 years with on average, 6% of citizens aged over 85 years recognised as carers. We know that these figures under represent the number of carers in Surrey Heartlands.

Health and care outcomes for people experiencing wellbeing issues are lower than those of our general population. We have geographical gaps such as suicide rates in North West Surrey; which have significantly improved since 2014 to around the national rate and form part of our community based support and wellbeing to ensure this is maintained.

3 Life expectancy is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities.

Where we are now

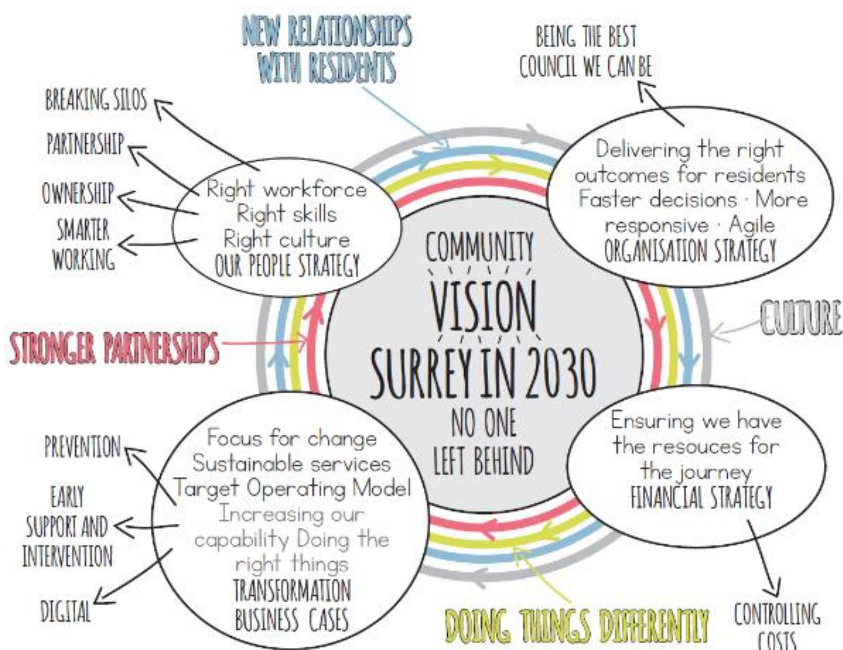
Using the life phases as the framework adopted within the Surrey health and wellbeing strategy, we have identified the current health and wellbeing of our population:

	Current	Areas of underperformance or inequality
Start Well	6.5% babies born at a low birth weight (7.3% nationally) 5.8% women are smokers at the time of delivery in Surrey (10.7% nationally) 10% children and young people live in poverty (25% nationally) Infant mortality rate is 2.5 per 1,000 births (3.9 nationally) Prevalence of overweight children in Reception (including obese) is 17.3% (22.6% nationally)	In Surrey there are also pockets of inequality, which have a significant impact on children's outcomes - both health related and more widely. 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 health such as obesity, isolation and difficulty accessing local support services.
Live Well	Healthy life expectancy at birth (F):68.1 yrs (63.9 nationally) Healthy life expectancy at birth (M):68.9 yrs (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)	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.
Age Well	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%. It is estimated that there are approximately 22,000 people with frailty in Surrey currently, expected to increase by almost 30% by 2030. 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.	Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by over 18%. As this population group 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.

Chapter 2: A Vision for Surrey

Through engagement with residents, communities and partners across the county we have developed an understanding of what Surrey should look like by 2030. Informed by the conversations we had; we have been able to create a shared vision for Surrey.

"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." [4]



Our ambitions for people
• 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
• 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.

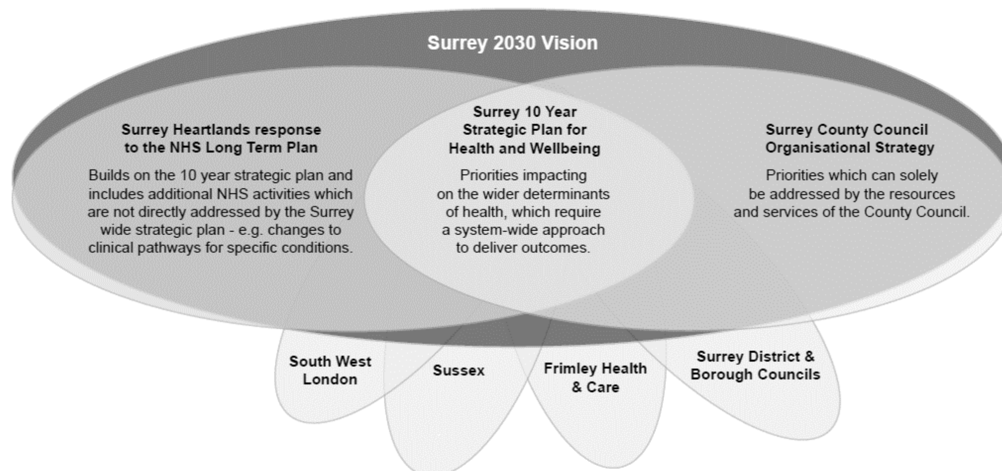
Whole System Priorities

Following on from this, Surrey's 10 year Health and Wellbeing Strategy[5] identifies the priorities for the Surrey-wide System, focusing on the wider determinants of health to create long-term and generational change for the population. 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. It is informed by views gathered through stakeholder workshops, formal surveys (Healthwatch Surrey[6]) and a public consultation on the Strategy. In

[4] https://www.surreycc.gov.uk/council-and-democracy/finance-and-performance/our-performance/our-organisation-strategy/community-vision-for-surrey-in-2030
[5] https://www.healthysurrey.org.uk
[6] \\NWSurrey.XSWHealth.nhs.uk\Users\clairefuller\Library\Containers\com.apple.mail\Data\Library\Mail Downloads\FBE398C9-8428-4CD8-B7D1-F68999336E63\ https\www.healthwatchsurrey.co.uk\wp-content\uploads\2019\09\NHS-Long-Term-Plan-Report-August-2019.pdf

addition, partners have made a commitment to continue to work with residents as the Strategy is implemented to find the best ways to achieve the outcomes.

As a result, it is the intersection between those priorities of Surrey County Council and those of the health System and signals the shift to a **greater preventative approach** and supports the delivery of local health and care plans in response to the NHS Long Term Plan and individual organisation strategies and plans and will serve to guide the targeted approach needed to ensure health inequalities are reduced and will serve to guide the targeted approach needed to ensure health inequalities are reduced.



It focuses on **three interconnected priorities**:

Leading healthy lives	Empowering our citizens to lead healthier lives. This includes individual lifestyle factors, but also considers built environments and how that impacts on health. This priority area is entirely focused on prevention, and about creating healthy and proactive people who take ownership of their health.
Having good mental health and emotional wellbeing	Enabling the emotional wellbeing of our citizens by focusing on preventing poor mental health and supporting those with mental health needs. Empowering people to seek out support where required to prevent further escalation of need, but this priority is also about creating communities and environments that support good mental health.
Fulfilling potential	Enabling our citizens to generate aspirations and fulfil their potential by helping them to develop the necessary skills needed to succeed in life. This is not only related to academic success, but also to wider skills and involvement in communities. Healthy lifestyles and emotional wellbeing are fundamental to fulfilling potential - this priority builds on this by empowering citizens locally.

Our framework for health & care outcomes

The life phases of 'Start Well', 'Live Well', and 'Age Well' are used as a framework for understanding the health and care outcomes in Surrey in the development of our Surrey 10 Year Plan and aligns with the NHS LTP approach to prevention and wellbeing. It has formed the development of strategic ambitions and priorities in Surrey Heartlands to drive generational and sustainable long term change through:

- Improved health and wellbeing outcomes for the population;
- Reduced health and care activity; and
- Reduced financial burden on the public sector.

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 - to nurture children in their early life. Helping children get the best start in life is both good for them and good for our society. Whilst most children in Surrey Heartlands do better than the national average, those who are vulnerable, experiencing poverty or with special educational needs have been doing disproportionately worse.

Most people in Surrey live healthier lives than the average UK citizen. However, this strong average performance often masks areas of underperformance, inequality, and where additional focus is required. By both focusing on the wider determinants and prompt diagnosis, and management of health conditions, we can reduce inequalities and unwarranted variation in outcomes. By working with our communities, we can support people to stay independent and resilient.

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by over 18%. As this population grows in size, there is likely to be an increase in the number of people with complex conditions & co-morbidities, such as dementia, diabetes, CVD & chronic kidney disease related to aging. It is important to create a support System that both provides for and encourages preventative choices to enable fulfilling later lives.

We are committed to delivering the priorities and outcomes set out in the Surrey 10 year health & wellbeing strategy, and below set out in this section how we propose to achieve this in Surrey Heartlands and respond to the NHS Long Term Plan through these.

1. Enabling people in Surrey to lead healthy lives	
We will empower our citizens to lead healthier lives. This includes individual lifestyle factors, but also considers built environments and how that impacts on health. In Surrey Heartlands we will be:	
1.1 Working to reduce obesity and excess weight rates and physical inactivity 1.2 Supporting prevention and treatment of substance misuse, including alcohol 1.3 Ensuring that everyone lives in good and appropriate housing 1.4 Promoting prevention to decrease incidence of serious conditions & diseases	1.5 Preventing domestic abuse (DA) and supporting and empowering victims 1.6 Improving environmental factors that impact people's health and wellbeing 1.7 Helping people to live independently for as long as possible and to die well
We will focus on improving care across the entire pathway. Therefore, as well as prevention, early intervention and out of hospital services described in our Health and Wellbeing strategy we will also prioritise:	
1.8 Providing children and young people with timely and appropriate health services	1.9 Improving care for major health conditions such as cancer, cardiovascular disease, stroke, diabetes, and respiratory disease
Expected Outcomes	
• People have a healthy weight and are active • Substance misuse is low • Everyone lives in adequate housing • Prevention of disease through vaccination and early diagnosis	• People are supported to live independently for as long as possible • Unwarranted variation is removed • Best practice is spread and adopted • Quality standards/ targets are met
2. Supporting the emotional wellbeing of people in Surrey	
We will support the emotional wellbeing of our citizens by focusing on preventing poor mental health in addition to supporting those with mental health needs. We will be empowering people to seek out support where required to prevent further escalation of need, but this is also about creating communities and environments that prevent poor mental health. We will be:	
2.1 Enabling children, young people, adults and elderly with mental health issues to access the right help and resources	2.3 Preventing isolation and enabling support for those who do feel isolated 2.2 Supporting the emotional wellbeing of mothers throughout and after their pregnancy
We will focus on improving care across the entire pathway. Therefore, as well as prevention, early intervention and out of hospital services described in our Health and Wellbeing strategy we will also prioritise: 2.4 Improving adult mental health services	
Expected Outcomes	
• People with depression , anxiety and mental health difficulties are identified early and supported • No one in Surrey feels isolated • Mental health surrounding pregnancy is supported	• Unwarranted variation is removed • Best practice is spread and adopted • Quality standards/ targets are met
3. Supporting people in Surrey to fulfil their potential	
We will support the emotional wellbeing of our citizens by focusing on preventing poor mental health and supporting those with mental health needs. We will be empowering people to seek out support where required to prevent further escalation of need, but this is also about creating communities and environments that prevent poor mental health. We will be:	
3.1 Supporting children to develop skills for life	3.2 supporting adults and young people to succeed professionally and / or through volunteering
Expected Outcomes	
• Children and young people who are deprived or vulnerable develop skills for life	• people have access to opportunities for personal fulfilment • increased opportunities for training and education for vulnerable groups

Figure 1

Determining our priorities

A key focus across the Surrey Health & Wellbeing Strategy and Surrey Heartlands priorities is not simply to treat the clinical symptoms, but to tackle the root causes of ill health; the wider determinants of health.

Wider determinants are a range of social, economic and environmental factors such as social inequalities. They determine the extent to which individuals have the physical, social and personal resources to identify and achieve goals and to deal with changes to their circumstances. The image in figure 2, highlights the factors relating to health outcomes and shows that clinical intervention or treatment contributes only 20% to an individual's health outcome.

As a health System these improvements can't be done alone. We are working with all our partners and in particular, expanding our partnerships to better include districts and boroughs, voluntary and community sectors to optimise health outcomes for our population.

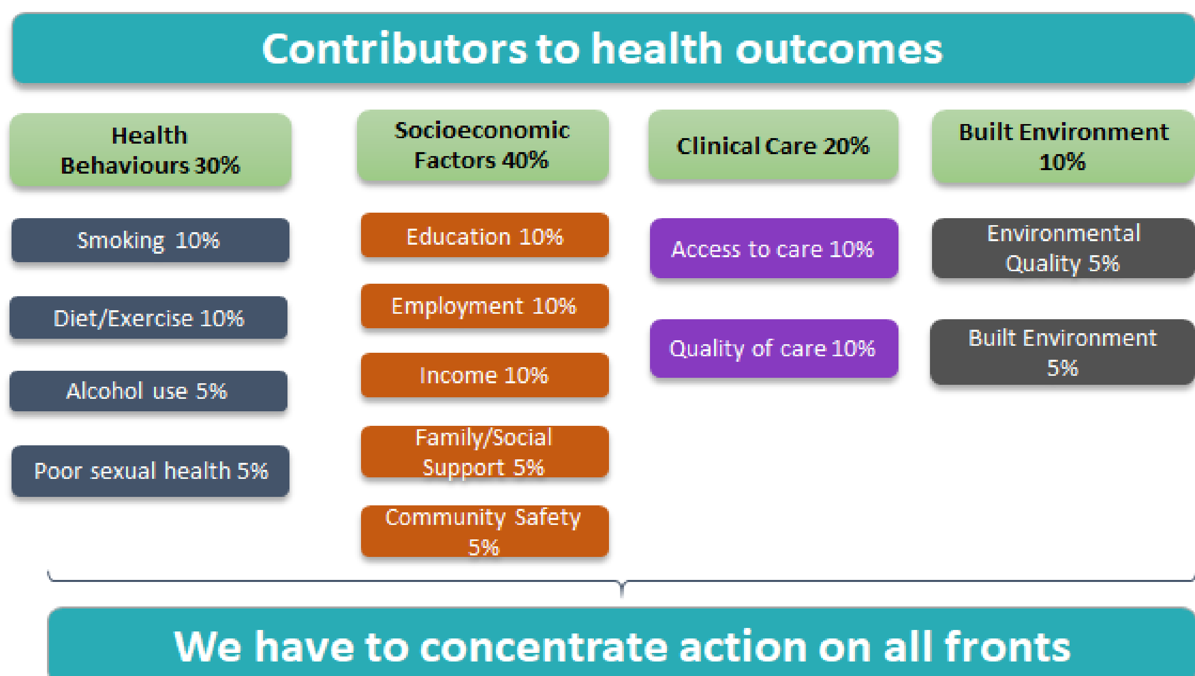


Figure 2

By March 2024, the target populations identified in the health and wellbeing strategy will be prioritised for action across the System with improved means of identifying the impact these are making within the outcomes being reviewed locally. Improvements in health outcomes should be occurring greater pace in this group than the general population to enable reductions in health inequalities.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. Our action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

The model in figure 3, shows a simplified version of the complex System that causes health inequalities. It shows the different factors that impact our health; where they stem from; and how both in sequence and simultaneously, they interact, multiply and re-enforce each other.

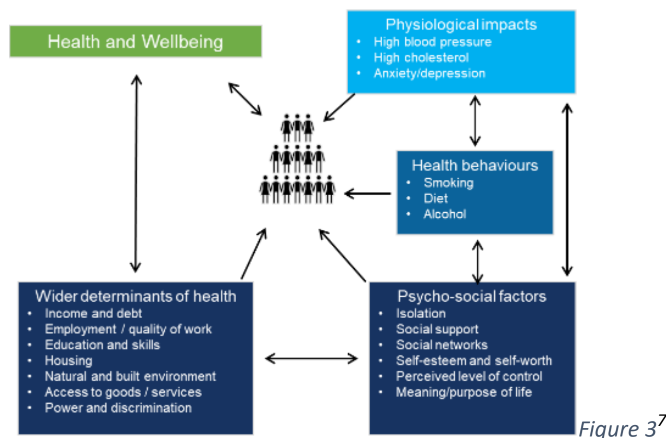


Figure 3[7]

Our local health and wellbeing strategy highlights that in delivering against our local priorities we need to ensure "no one is left behind". This is vital to ensure that health inequalities that are experienced both geographically and by different population groups are reduced and not amplified by a simple untargeted approach.

Population Health Management (PHM) is an approach aimed at improving the health of the entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner organisations. We are using PHM with the aim to achieve improvements in the areas shown in figure 4.

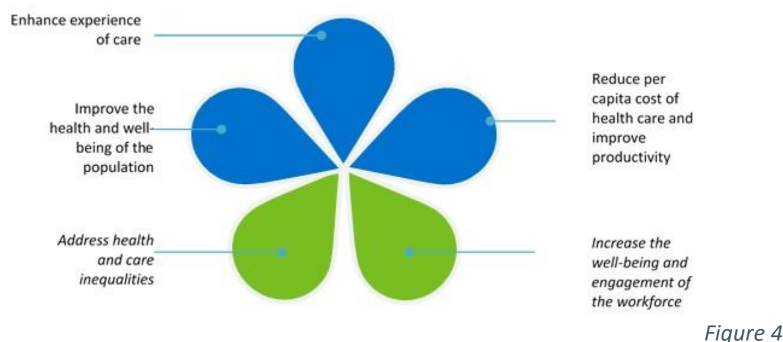


Figure 4

To avoid any groups of the population being left behind, we will focus on tackling our priorities across the entire population, as well as within **four specific target groups of people which are often overlooked or most at risk**. We will consider groups with protected characteristics within all these population groups as we implement our delivery plans.

ONE

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.

TWO

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.

THREE

Those people living with illness and / or disability, including long term conditions, multi-morbidities, 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.

FOUR

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.

FIVE

The 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 and enabling self-care.

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[7] Adapted from the health promotion model in Labonte, 'Heart health inequalities in Canada: Models, theory and planning', Health Promotion International, vol. 7, no. 2, pp.121

Our aim is to achieve the highest level of Population Health Management (PHM) maturity during the next five years we will expect PHM to underpin System and local transformation by being the method by which improvement is made and the check & balance to mitigate unwarranted variation and health inequalities for our populations. These are being woven into our service plans and will bring together the different elements of the Population Intervention Triangle in the most appropriate way (figure 5).

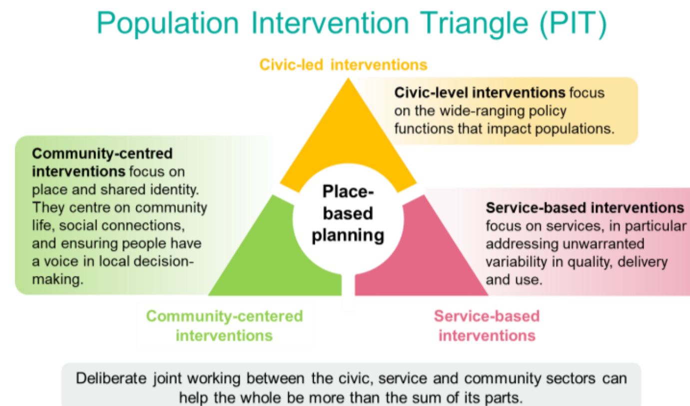


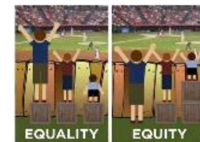
Figure 5

In Surrey Heartlands alongside those areas already beginning to address these target populations, further opportunities exist across the activity described in the System such as for:

- Improved diabetes diagnosis rates
- Improved pre-diabetes rates
- Improved bowel screening rates
- Improved cervical screening rates

You can find out more about our approach in the 'Population Health Management Strategy' (appendix 3).

Through the work described in this document for example, we expect that when considering our target population groups, there will be increased and comprehensive screening and Proactive identification of those who are pre-diabetic and not engaged with GPs. Our challenge is to keep asking "what's fair?"



Prevention

In support of the continuing work of Public Health England undertakes to make the public healthier, reduce differences between health groups by promoting healthier lifestyles and protecting the nation from public health hazards, the LTP sets out a turning point in how we provide healthcare and support our citizens by moving away from prioritising treatment, to one that can also predict and prevent poor health. These activities known as 'prevention'.

Our Health and Wellbeing Priorities want to promote prevention and early diagnosis by empowering citizens to lead healthy lives and become proactive in the ownership of their health (figure 1). Outcome measures have been identified and are included within our delivery programmes; pending final approval by the Surrey Health and Wellbeing Board in December 2019 (appendix 4). You can read about our work to progress this work in chapter 5.

Surrey Heartlands has gone on to determine its priorities which support both the *Surrey Health and Wellbeing Strategy* and the delivery requirements of the *NHS Long Term Plan*.

Each **Integrated Care Partnership (ICP) has further defined their local priorities**, reflecting local need and addressing key determinants of health, whilst supporting these umbrella System Priorities. Where relevant these align with the delivery plans for the health and wellbeing strategy that will be published in December 2019.

Overall risks to delivery

We have a number of significant risks to our ability to deliver the System Outcomes and NHS LTP commitments. These are shown below and mitigations are described within the key programmes of work in this plan.

- Workforce
- Financial sustainability
- Speed of digital mobilisation
- People's ability/confidence to use digital options
- Digital connectivity

Communications, citizen-led engagement & social research

We want our plans to be based on genuine, evidence-led citizen and stakeholder engagement to ensure our services meet the needs of local people.

Our published ICS **communications and engagement strategy** (2018) defines the activity needed to support the Surrey Heartlands System in achieving its objectives, building on successes so far, being open and honest about the challenges and opportunities we face, and continuing to engage and involve audiences across the local System and beyond. Above all we want our developing plans to be based on genuine, evidence-led citizen and stakeholder engagement to ensure our services meet the needs of local people.

Our strategy will support the implementation of this plan through the following strategic goals:

- Work in a genuine partnership with citizens, patients, VCFS, local government and wider stakeholders
- Create buy-in and trust with key stakeholders in our wider System and its plans
- Influence behavioural change (to support our prevention and early intervention agenda) and ensure local people understand the services that are available to them
- To support a wider cultural change with both staff and citizens in the way services can be delivered in the future
- To celebrate success with staff, citizens and stakeholders, across a variety of channels

Our strategy builds on our early priority in Surrey Heartlands to understand and implement new approaches to citizen engagement in addition to traditional communication and engagement routes, as illustrated in the Surrey Heartlands engagement spectrum in figure 6.

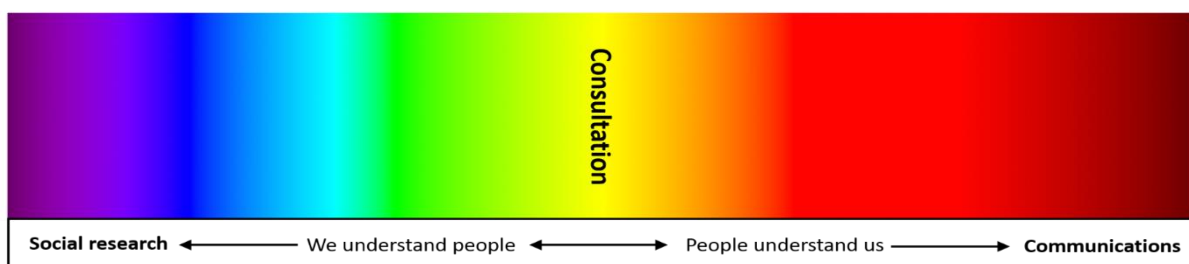


Figure 6

Our innovative approach to citizen insight uses robust social research methods to complement BAU communications and engagement activities. We employ quantitative research methods through our demographically representative online citizen panel of approx. 1,800 residents, and our citizen ambassadors (in partnership with Healthwatch Surrey) carry out grassroots qualitative work. We are applying the same tactics to engaging with our clinical and professional (C&P) workforce, with a reference panel currently in development and implementation of C&P Ambassadors across the System. To gain traction, we are piloting a co-produced Participation Game, Co-lab, which facilitates mixed groups of staff, citizens and stakeholders working collaboratively to plan a meaningful programme of engagement. The insights and evidence gained through our mixed-methods approach helps to guide decision making.

Stakeholder engagement

Ongoing citizen and stakeholder engagement have been key to the development of our priorities and plans across the Surrey Heartlands System. The principles of participation and co-design are at the heart of the way we do business and are now embedded within both our transformation programmes and wider System-wide planning.

Surrey Health & Wellbeing Strategy

Our overarching System strategy, the *Surrey Health & Wellbeing Strategy*, has been influenced by a number of significant engagement programmes, specifically:

- Surrey Residents Survey
- Citizen engagement on the Surrey County Council 2030 Vision
- Connected care Survey
- Mental Health Survey

Outputs from these wider engagement programmes contributed to the development of Surrey's three priority areas based on the following emerging themes or 'areas of concern':

- Population changes including the impact on public services of an ageing population and experiences with and access to services for more vulnerable members of the population
- Transport including road congestion levels, and the quality, reliability and availability of public transport
- Housing including housing supply and affordable housing
- Inequality and deprivation including children with special educational needs (SEND) and children (and their families) from deprived backgrounds
- Public services including access and availability of services, including existing pressure on health services, mental health services, services for children with SEND and looked after children
- Economy including current state of high streets
- Community Safety including visibility of police services
- Environment including pollution levels, waste collection & disposal, new development impacts on wildlife
- Local democracy and partnership including Council tax levels and transparency around spend

Much of the feedback also related to the way care is provided, for example wanting services provided in a community setting that provided for a variety of needs. The use of digital solutions and technology was also highlighted, with residents expressing views on the importance of using these to both communicate with residents and to provide services and information. These viewpoints were also fed into the wider strategy.

You said "It is important to me to get care from professionals who know about my history which is accurate and up-to-date" ***We did*** Our focus on Digital & Technology will drive interconnectivity between organisations to support the public in 'only needing to say it once'.	***You said*** "Giving to others through small acts of kindness to other people, or larger ones such as volunteering in my local community help to boost my mental health and wellbeing" (95% net agreement). ***We did*** We are highlighting the importance of Community Development and the further engagement with 'natural communities' to determine how places can take forward the priorities which will be the most impactful for them, and develop stronger communities (promoting mental health & wellbeing).	***You said*** 22.37% of respondents to the Surrey Residents Survey were dissatisfied with council services for people with disabilities or mental health problems (including further feedback on satisfaction with services and neighbourhood 'issues'). ***We did*** We are prioritising the population cohort of children with SEND and adults with learning disabilities and/ or autism.

A number of specific partner and stakeholder events were held as part of the developing strategy. Once drafted, further engagement took place with citizens and stakeholders to 'test' the key priorities before the strategy was approved by the Health & Wellbeing Board in May 2019.

Ongoing engagement in transformation programmes and service redesign which contribute to our overall plan

Citizen and stakeholder engagement is integral to all our transformation programmes and in continuing to improve and develop health and care services for local people. This ensures that our plan has been genuinely influenced by the views of local people and built around their needs. Over the past year, contributing to the key themes and detail within this plan, we have undertaken a number of engagement and research programmes, examples of which include:

- **Women and children's:** our citizen engagement programme has been instrumental in developing our plans for women and children's services including work undertaken by our dedicated Citizen Ambassador, Citizen's panel and a number of wider stakeholder events focused on the First 1000 days.

- **Emotional wellbeing mental health services for children and young people:** significant engagement programme (early 2019) with children, young people and their families to influence

Surrey's new Children's strategy, our transformation programme to improve services and the procurement of a new CAMHS contract (for March 2021)[8].

- **Cardiovascular disease project:** engagement which resulted in the development of our community based diagnostic programme for atrial fibrillation and hypertension.
- **Digital - citizen panel survey:** a survey using our Citizen's panel in early 2019 exploring people's attitudes towards data sharing, demonstrating a general demand/agreement for health and care to share information, and high levels of trust in the NHS [with personal data] compared to other services e.g. Facebook, at the time of the Cambridge Analytica scandal
- **Urgent care:** ongoing engagement around our *Big Picture* and *Better Care Together* urgent care programmes are influencing our planning and option development for how we provide urgent care services in North West Surrey and Guildford & Waverley, taking into account new national guidance on Urgent Treatment Centres.
- **Planned Care Principles:** our citizen engagement methodology has been used to develop a set of Planned Care Principles, through stakeholder interviews and a World Class Café style event with local residents. Outputs have influenced our planned care strategy, toolkit and a set of principles which we are embedding into planned care pathways.
- **GP online consulting:** specific engagement with citizens around online GP consultations have given us a clearer understanding of the key benefits and concerns citizens have about this type of new service and how we develop and procure these services in future.
- **Learning disabilities and special educational needs:** as part of their commissioned engagement around the Long-term Plan, Healthwatch Surrey worked with us to agree some targeted engagement around people with learning disabilities and special educational needs, as key themes within Surrey's Health & Wellbeing Strategy. Two key themes emerged:
  - Families told us that having a child with SEND / LD should be less of a battle
  - People involved in care delivery need to do more to support transitions from 'childhood' to 'adulthood'

These themes are being taken forward within our plans; the full report and our response can be found here: https://www.healthwatchsurrey.co.uk/our-work/reports-and-papers/project-reports/

Wider engagement to support implementation of our plan and key themes
Nationally **Healthwatch** was commissioned to undertake local engagement around implementation of the Long-term Plan. Earlier in 2019, Healthwatch Surrey conducted a survey of local people to explore their views on topics relevant to local implementation, with the following key themes emerging:

- People want access to information, help and treatment when needed
- People want to play an active role when making decisions about their care and treatment
- As people age, they want to be able to stay in their own homes for as long as possible
- Technology can play a valuable role in increasing the efficiency of care

These themes are built on within our plans, with the full report and our response available here: https://www.healthwatchsurrey.co.uk/our-work/reports-and-papers/project-reports/

[8] More detail available at: http://www.guildfordandwaverleyccg.nhs.uk/info.aspx?p=7

We have also held a number of specific events looking at the overall themes within this long term plan submission (figure 7), testing our priorities with local people and stakeholders and will continue to do so on an ongoing basis.

Date	Key topic discussion	Audience
5th March 2019	Key themes of draft Health & Wellbeing Strategy	Stakeholders across Surrey Heartlands including patients and public representatives
17th July 2019	Overarching themes in LTP; specific priorities for local Integrated Care Partnerships	Stakeholders across Surrey Heartlands including patients and public representatives
2nd October 2019	Digital and outpatient transformation; other key themes within LTP (mental health, workforce, integrated care)	Stakeholders across Surrey Heartlands including patients and public representatives

Figure 7

Ongoing engagement

Engagement doesn't stop once this plan has been submitted. We will continue to work in partnership with local people as we refine and implement these plans over the next five years, ensuring they remain fit for purpose and continue to meet the needs of our citizens and stakeholders.

Chapter 3: Developing the Integrated Care System

Surrey Heartlands is an Integrated Care System (ICS) or System. As such we are working in a new way with local health and care partners to make decisions about how we use our collective resources to meet standards and improve the health outcomes of the people we serve. We have developed an ICS Strategy (appendix 5) and launched an ICS Development programme looking at:

Care design & delivery model	Collaboration
Our ambition is to fully integrate health and care services where they are provided across Surrey's geographical footprint and offers economies of scale, strategic oversight and reduces variation. We will be offering greater autonomy to geographical ICPs with delegated budgets enabling ICPs to develop services based on population heath needs around Primary Care Networks. We will continue to work with the Surrey County Council to explore the integration of commissioning and operational services including Children's Services, Mental Health Services and Continuing health care.	We are pursuing our ambition to collaborate across partners across a number of key enabling functions which has involved: • Joint system wide ICS appointments for Estates, Workforce and Digital. • Exploring where there might be potential benefits in working together (e.g. Business intelligence, IG, Digital Estates) either across Surrey Heartlands or at a more local level. • Developing place based leadership teams utilising the management expertise across all partners • We are developing a transformation support unit with SCC to drive our key transformation priorities
Quality	
We are agreeing what quality means in our System and quality standards that can be applied across Surrey Heartlands. We are moving to a multidisciplinary professional leadership model for Surrey Heartlands.	
Governance & decision making	**Communications & engagement**
We are designing our 'System architecture' to support robust governance and decision making, and to ensure a single approach to regulatory alignment and the development of new contracting forms.	We are ensuring that our communications and engagement teams and strategies are aligned so that the public and staff can be involved in the development of our plans.

Our governance structure

The Health and Wellbeing Board is our senior decision making board, acting as the ICS partnership board, holding the health and wellbeing strategy (appendix 6) which includes our response to the NHS long term plan as a component of this strategy. The Leader of Surrey County Council, is the chair of the Health and Wellbeing Board and the ICS independent chair, bringing democratic accountability to the role of independent chair, and transparency of decision making, as the Health and Wellbeing board meets in public.

Decision making is collaborative and unambiguous, whilst being representative of all partners in Surrey Heartlands is central to enabling our development and delivery. East Surrey ICP is now part of this architecture.

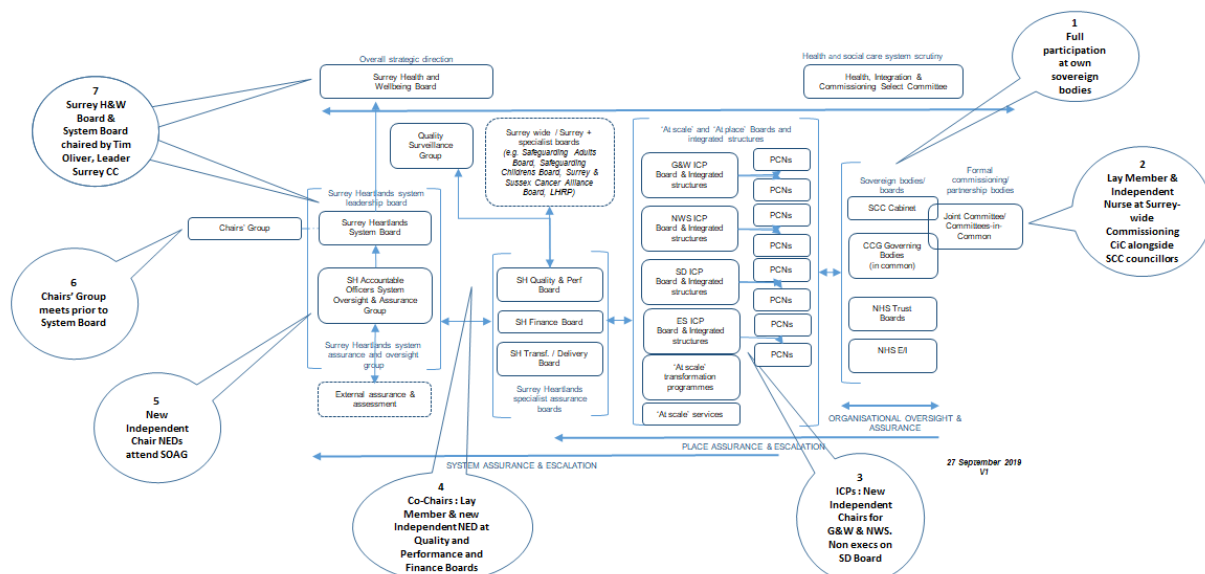


Figure 8

We have a number of services where the definition of "place" is "Surrey"; these are our "at scale" services. The decision to designate services such as children, mental health, learning disability and autism at scale was supported by the rationale that the services cover a larger geographical footprint and benefit from collaboration whilst maintaining strong links with the place based ICPs. You can read more about these services in chapter 4. Governance for these services is convened through the 'at scale' transformation board.

The chairs forum provides oversight to the system board and the Non-Executive Directors & lay member's forum acts as a reference group for ICS development.

ICS led assurance, monitoring and tracking performance

Surrey Heartlands ICS has drafted an Assurance Framework Finance, Quality and Performance, which is pending approval. The framework brings together an integrated approach to assuring delivery of outcomes across Surrey Heartlands' partners as part of our devolved status.

Surrey Heartlands uses its governance structure to receive assurance. Assurance will be sought through a range of approaches including observation of how business as usual is conducted e.g. ICP and Specialist Board meetings; seeking assurance that specific issues are identified and being addressed through the existing governance structures for ICP and Surrey Wide services. Assurance activity through this approach will also seek to build confidence and assure transformation and delivery of the Surrey Health and Wellbeing Strategy outcomes.

Surrey Heartlands is working with national and regional teams to ensure that the new Safeguarding architecture will fit with the wider quality approach for Surrey Heartlands and assure the Surrey Safeguarding Board. The assurance process will be supported by the Surrey Heartlands integrated assurance dashboard, which is being finalised, enabling all partners to undertake ICS led-assurance at an individual and collective level from a GP practice to the ICS as a whole.

Assurance packs and documentation will adhere to the principle of reducing duplicative processes and will utilise the most recent monthly ICS quality, performance and finance reports available. Regulator data, reports and notices will also form part of the documentation to ensure there are no gaps in the triangulated discussions.

The approach will support the ICS partners to identify where, when and what type of support may be required and seek to secure that support to enable remedy or improvement to deliver the best outcomes for the population.

There are up to 4 members of the ICS and NHSE/I virtual assurance team who attend ICP Board meetings on a quarterly basis in an observer's capacity. Actions will be logged by the ICS Assurance team. Where there is an agreed lack of assurance, this will be escalated through the ICS assurance architecture to the System Oversight and Assurance Group (SOAG).

System enablers and developing our capabilities

Figure 9 shows the activities that will make it possible to develop our System and require to be fully embedded to achieve success. We call these 'enablers'. It is clear we need to work in a different way and develop new capabilities if we are to deliver our priorities and meet our ambitions. Removing barriers that might be preventing collaboration across the different parts of the System will be critical for success. The work of these enablers is described later in the delivery plan.

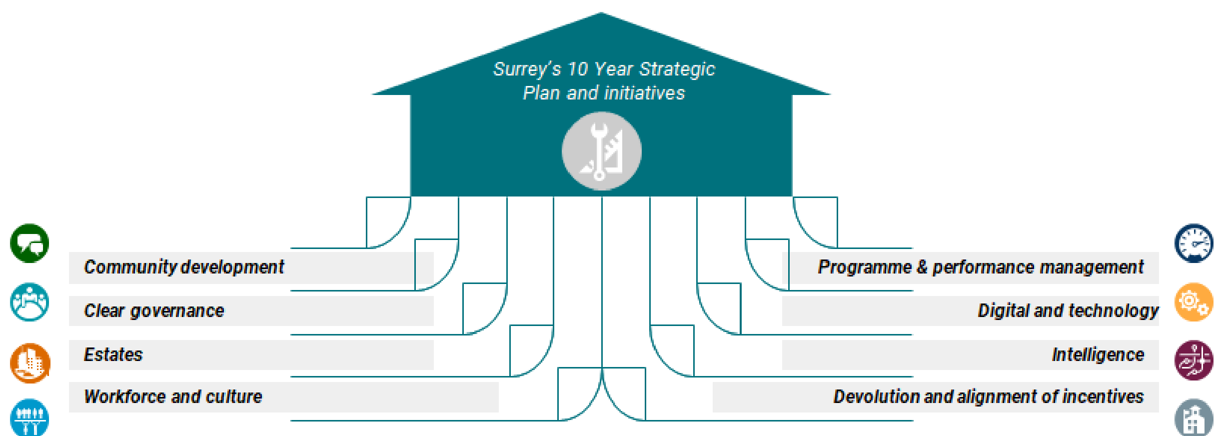


Figure 9

Our Integrated Care Partnerships

Localising the ICS strategic delivery plan is critical to ensuring successful delivery. Integrated care partnerships (ICPs) are the vehicle that drives planning and delivery at a local level, also referred to as 'place'. They are partnerships working together to deliver care (by agreeing to collaborate rather than compete). These partners include hospitals, community services, mental health services, ambulance services, GPs, social care, district & borough councils, voluntary, community and faith sectors and commissioners. ICPs will plan, prioritise and deliver care at place for populations of 250,000-300,000. They will adopt evidence-based, population health management approaches to design and deliver care models centred on individuals, integrating mental health, physical health and social care.

Surrey Heartlands includes four place (East Surrey, Guildford & Waverley, North West Surrey & Surrey Downs) and one service based (Surrey Wide Services) Integrated Care Partnerships (ICPs).

One of their priority objectives is to focus on their population's health & care as shown in figure 10. Their development will allow the opportunity to address areas of 'wider determinants of health' for their local communities and citizens within their catchments.

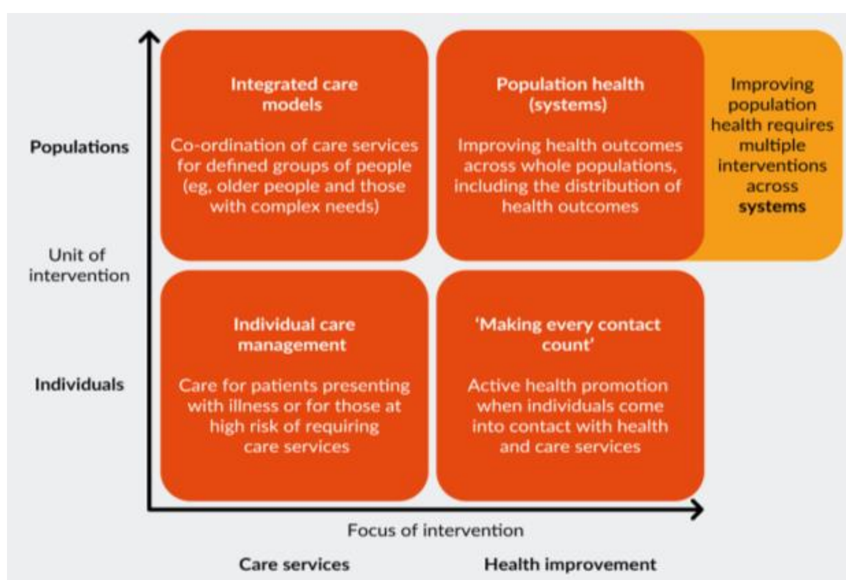


Figure 10: Source Kings Fund

You can read about the development of our ICPs and their work to deliver 'new models of care' in Chapter 4.

Our Devolution Opportunities

Our ambition to support people in Surrey to live longer healthier lives ultimately requires a shift to a preventative approach, addressing root causes of poor health and wellbeing. Recent signals about a renewed commitment in central government to promote devolution to local areas represent a compelling opportunity to accelerate the achievement of this ambition. Our first devolution agreement, signed in 2017, focused on greater local control of health and care commissioning decisions and closer alignment of the commissioning responsibilities of the NHS and local government. The next stage would be to achieve even greater integration of services extending beyond health and social care to include public health, housing, employment and other local services that function as the wider determinants of health. Proposals are currently being developed around the devolution of NHS estates in Surrey as part of ambitions to secure the maximum value from the local public sector estate and, through it, the ability to create a local transformation fund that would enable us to support improved outcomes for residents on a financially sustainable basis.

As a devolved health and care system, we can place health and wellbeing as part of the infrastructure of prosperity and allows much better alignment with wider work around education, skills, work and housing to secure the best outcomes and public value through much closer working between Surrey County Council and the NHS. This model is supported by the ICS Accountable Officer having a formal contract with NHSE to discharge devolution responsibilities.

Specialised Services

By March 2024, we expect Surrey Heartlands will have robust local System leadership in the planning and delivery of ***specialised services*** *for the population, aligning these to locally commissioned services. Where specialist services are provided outside the ICS, we will ensure our population have pathways integrated with local services.*

This integration of whole pathways will deliver benefits to patient outcomes and experience, a reduction of unwarranted variation and improved value for money. Investment in prevention and management earlier in the pathway will deliver a reduction in demand for specialised services and an integrated approach will enable services to be more responsive to the needs of the local population. This will contribute to improving the health of our local population and sustainability of current

services and enabling simple access to the latest advanced treatments for our citizens when needed. We will work to close the gap between access to services based on proximity to services. We have identified 4 key drivers for our vision which are:

- Design and deliver high quality services for the population of Surrey Heartlands
- Engage the right people in designing and delivering services
- Optimise the use of limited resources; workforce, finances and capacity
- Do the right thing for our population; agree System ambitions across providers, commissioners and specialist commissioning teams and understand and manage risk

Surrey Heartlands has relatively little provision of specialised services within its geography apart from the cancer centre at the Royal Surrey that serves a much wider population than just SH ICS as well as leading the Surrey Hepatology Operational Delivery Network. Epsom and St Helier provide specialist renal services, ASPH cover cardiology and vascular services and SaSH have good integration with specialist services on their campus. The Royal Marsden is the main cancer provider for the SD ICP population. Our population does generate a significant part of the London spend on specialised services with the South East as a whole making up 28% of the total London spend and much of this is provided by St George's University Hospitals Foundation NHS Trust. It is therefore crucial that we work with the London System to shape specialised services to be delivered with the needs of the Surrey Heartlands population at the forefront. It is also crucial that services are integrated and delivered closer to patient's local communities, enhancing shared care with tertiary centres wherever possible. We will consider the sustainability of local providers as we consider repatriating services which are in the best interest of patients and make better use of our limited financial resources.

We have developed a Specialist Commissioning Planning Board which currently involves shared decision making with SE Regional colleagues and ICS Partners. Together we are setting principles for addressing the challenges and areas we want to see change in as well as streamlining and reducing duplication in our contract management processes. We currently have 8 priority work streams with more emerging. We are already working with surrounding Systems, London and Frimley Health ICS to improve alignment of services provided for our patients with a seat at the London specialised Commissioning board. For all our priority areas, we aim to increase care delivered locally and reduce the number of unnecessary face-to-face appointments making better use of digital options to deliver care as described in the LTP. We will also support patients to make informed choices about the treatment, support and intervention they receive throughout their care pathway.

Vascular: we will build on existing work to agree a new delivery model which will ensure our providers are compliant in providing the best evidence-based care and outcomes for our population as locally as possible.

Renal: we will work as part of the South London and Surrey Clinical Renal Alliance, working on the already identified priorities; improving the transplant pathway, improving vascular access and implementing supportive care. We will work with Primary Care networks to improve the front end of the renal pathway and local secondary care treatment and advice working to improve opportunities for shared care to minimise patient travel.

CAMHS: we will develop the offering for CAMHS tier 4 services for our population to ensure that primarily our patients are supported within their own community and only have to travel to receive care when absolutely necessary. We will work as or with a provider collaborative to ensure that our patients, have access to the highest quality care when they need it and enabling their families and carers to remain connected.

Neurology: we will actively engage with the South London Neurology ODN to ensure that we are able to influence specialised services for our population. Our aim is that patients receive their care as close to home as possible, only having to travel to a specialist centre when absolutely necessary and optimising the use of digital opportunities and shared care. We will explore network delivery options to enhance local sustainability.

Paediatric Intensive Care: we will work with the relevant networks to identify improvements and other opportunities resulting from the national review currently under way. Working with the Surrey Children's Partnership and local providers we will Identifying babies whose admission to a neonatal unit could be avoided, and to promote the understanding of the importance of keeping mother and baby together when safe to do so. Implementing the recommendations of the national Neonatal Intensive Care, Paediatric Intensive Care and Paediatric Surgery reviews and further developing the Paediatric Critical Care network.

Cardiology: we will work across the System to integrate and standardise pathways as we develop a new Cardiac Network for Surrey. We will improve management within Primary Care and support citizen engagement programmes which help prevent complex high cost care later reducing demand for specialised services. We will build on the successful atrial fibrillation and high blood pressure identification programmes run with community partners. Savings from these can then be reinvested to deliver System priorities.

Specialist Activity Management: we will work to understand the tail of small levels of specialist activity for our System and be proactive in working with NHSE specialised commissioning to review contracts, coding and compliance of providers and exploring ODN and other service models to improve patient outcomes.

Cancer: our cancer agenda will be delivered in partnership with the Surrey and Sussex Cancer Alliance working with our ICPs to deliver major change to care pathways. We are supporting the implementation of the enhanced supportive care programme within the Royal Surrey linking this to other transformation work. You can read more about our cancer delivery plans in chapter 6.

We expect citizens to see over the next 5 years:

- Where appropriate, appointments will be closer to people's homes to avoid unnecessary travel, particularly into London
- End to end integrated pathways which are more responsive to the needs of the local population with significant elements of the pathway delivered in the ICS for specialist services
- Improved operational effectiveness and consistency through System-level management of pathways and capacity
- Greater investment in prevention and clinical management earlier in the patient pathway resulting in improved value for money, driving a reduction in demand for more complex specialised services later

You can read more about NHS England South Region's Specialised Commissioning response to the NHS LTP in appendix 7.

Screening and Immunisations

We are working in partnership with NHS England which is responsible for commissioning public health services including NHS screening services, immunisation services, and child health information services. The responsibilities are set out in the annual NHS public health functions agreement, made under section 7a of the NHS Act 2006. The agreement is known as the section 7a (s7a) agreement.

NHS England is supported by, and works in close collaboration with, Public Heath England (PHE) as public health advisors and providers of data and delivers through its regional public health commissioning teams (PHCT) with their embedded screening and immunisation teams (SIT). Through the s7a agreement, NHS England commits to deliver against levels of performance as measured by agreed standards and to reduce variation in local levels of performance. Each year the agreement also sets out planned changes in s7a services to be implemented.

Commitments in the Long Term Plan

The LTP guidance set out the following specific commitments for improvements and service change for screening and immunisations, where Systems will work with NHSE on delivering for our local population:

- improving bowel, breast, and cervical screening uptake
    - bowel screening Surrey Heartlands current rate[9] 57.9% compared to England average 57.7%
    - breast screening Surrey Heartlands current rate[10] 70.2% compared to England average 71.7%
    - cervical screening Surrey Heartlands current rate[11] 75.5% compared to England average 75.2%
- implementing the HPV vaccination programme for boys from September 2019
- roll-out of FIT120 including changing the starting age from 60 to 50, at a timescale to be agreed nationally
- roll-out of HPV Primary Screening in the cervical screening programme by 2020
- taking forward the findings of the Sir Mike Richards review into cancer screening (when published)
- ensuring that all screening and vaccination programmes are designed to support a reduction in health inequalities by working with PCNs
- improvements in child immunisation to base level standards
- implementation of the digital child health record “e-red book”

NHSE commissioners alongside the ICS as part of its devolved services, will lead the implementation of the commitments above in partnership with local Systems and other partners such as PHE, HEE, and local authorities.

Implementing the HPV vaccine for Boys

NHS England is working with existing providers of school aged immunisation programmes to implement the two dose HPV vaccination programme for boys. The programme will be delivered at the same time as the girls’ programme. In some areas, this will mean the first dose will be delivered in the autumn term (September 2019); in other areas, the first dose will be delivered in the spring or summer terms in 2020. National materials will be made available to providers and a national publicity campaign will be run to promote the programme.

Improvements in child immunisation to base level standards

Childhood immunisation rates in 0-5 year olds in Surrey are one of the lowest in the South East, although we have seen an increase in coverage over the last few years. For example, in **Surrey population vaccination coverage for two doses of MMR at 5 years was 74.8% in 2015/16, compared**

[9] Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %) (PHE Fingertips)
[10] Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %) (PHE Fingertips)
[11] Women, aged 25-64, with a record of cervical screening (last 5 years) (PHE Fingertips)

to 81.7% in 2017/18. This compares to an MMR coverage at 5 years of 87.2% seen both in the South East Region and across England in 2017/18[12].

School based immunisations coverage is more in line with regional and national coverage, for example population vaccination coverage for one dose of Human Papilloma Virus (HPV) vaccination in 12-13 year olds (females) was 87.3%, compared to a coverage of 88.6% in the South East Region and 86.9% in England in 2017/18[13]. Although population vaccination coverage for two doses of HPV vaccination in 13-14 year olds (females) was 76.1%, compared to a coverage of 84.6% in the South East Region and 83.8% in England in 2017/18.

Surrey performs better than both the South East Region and England in population vaccination coverage for influenza vaccination in 2-3 year olds, which is 46.8% in Surrey, compared to 46.5% in the South East Region and 43.5% in England in 2017/18. **The target coverage is 50% for influenza vaccination in 2-3 year olds**. The school aged childhood flu programme has been a real success with the achievement of uptake rates. In 2017/18, the average uptake amongst Reception aged children to Year 4 was around 70% which was higher than the local, regional and national average. This year the programme will be extended to include all Primary School aged children (Reception to Year 6).

The causes are multifaceted and include misinformation, access issues, and a lack of awareness about disease prevention. The poor coverage has led to the World Health Organisation removing our measles elimination status.

In response to this the national MMR elimination strategy was published in January 2019, and local public health commissioners have developed an MMR action plan which will address the decline in MMR coverage. Our ambition is to increase the coverage of vaccinations by rising the percentage of 5 year old children with 2 doses of MMR from **our current rate of 81.7% to 93.8%** and **reduce the instances of Measles** per 100,000 from the **current rate of 3.5 to 0**.

Improvements to the Child Health Information Service (CHIS), including improved, and where possible, automated data flows between GP practices and CHIS, will be a priority to ensure accurate measurement of uptake. NHS England will work with ICPs, PCNs and their constituent practices to ensure timely access for all children to the immunisations recommended for them in line with the national schedule.

We will hold a workshop in January 2020 to focus on childhood immunisation in 0-5 year olds, as this reflects the poorest immunisation uptake. We plan to hold a second event for school based immunisation (5-19 years) in the summer of 2020. Complimenting this, we expect to undertake a survey to capture patient/public voice with focus groups to explore attitude/barriers to immunisation during October and November 2019. Combined with a stakeholder event highlighting issue in December.

Implementation of the digital child health record "e-red book" by 2021

The Digital Strategy for Child Health sets out ambitions for offering a digital child health record ("e-red book") to help parents record information about their child's health, including immunisation records. NHS England will develop a national service specification and local public health commissioners will support its implementation at local level, in conjunction with the local Child Health Information Services

Direct Commissioning

NHS England directly commissions a number of health services for our citizens. Figure 11 describes the South East Region Team's commissioning responsibilities, priorities and expected outcome

[12] https://fingertips.phe.org.uk/profile/child-health-profiles

[13] https://fingertips.phe.org.uk/profile/child-health-profiles

measures to assure their delivery of the NHS LTP for dental services. You can read their full service delivery plan in appendix 8.

Dental – Primary Care and Secondary Care

The NHSE/I South East Regional role covers direct commissioning of this service. It covers around, 200 contracts with a £417m budget for Mandatory Dental Services, Urgent Dental Care, Orthodontics Intermediate Minor Oral Surgery, Special Care Adults, Paediatrics, Sedation, Restorative, Secondary Care (in and out of area), Helpline and Dental Electronic Referral System. The table following describes the priorities, challenges and improvement metrics for these. You can read the full general dental needs assessment for services in Kent, Surrey and Sussex in appendix 15.

National priorities 2019/20 -2023/24	Local Priorities	Strategic challenges	'Metrics'
BAU Contract management: - GDS / PDS - Orthodontics - UDC - Minor Oral Surgery - Community Dental Service (Special Care Adults & Paediatrics) - Restorative - Secondary Care commissioning/contracting **BSA commissioning support roll-out to all areas** **Deloitte Internal Audit** recommendations – to be operationalised into standardised BAU processes	Review SE-wide processes to agree new SE operating model to maximise team efficiency and effectiveness in context of commissioning vs BAU functions and compliance with Dental Policy Book Quarterly Dental Assurance Framework (DAF) monitoring review Year-end/mid-year review with Business Services Authority (BSA) pilot expansion **Surrey Heartlands** Devolution – 'seat at the table' operating model **Secondary care** RTT issues and reporting/action plans by specialty. Main secondary care priority is to remove all non-dental activity & to ensure accurate coding & full use of Dental Electronic Referral System (DERS) in KSS **Accreditation of tier 2 providers** to achieve assurance re clinical safety and effectiveness of services **Thames Valley – care pathways** in line with NHS England Commissioning guides to ensure treatment in most appropriate setting	- Surrey Heartlands Devolution – meaningful plan to deliver the vision - Reduce tooth extractions – decay children aged 10 yrs &under - Contract reforms / prototypes - Resources (includes financial, workforce, premises) to support strengthening of care pathways - Expertise and capacity to initially accredit and monitor safety and effectiveness of services	- Improving Access (BSA vital signs Child/12 months Adults/24 months) - Vital signs – Patient experience / F&F test – S13 Q compliance – Market intelligence – Accreditation systems in place
Secondary Care - planning/contracting round (KSS 9 contracts plus 7 out of area) (TV 4 contracts plus 5 out of area) (Wessex 9 contracts plus 5 out of area) **Re-Procurement of services** Planning: Oral Health Needs Assessments Improving access to primary care Improving access for more vulnerable patients Improve oral health overall and for more vulnerable patients Assurance Re: clinical effectiveness of services provided	Orthodontics procurement mobilisation: – >60 new contract awards, transfer live patients & provider exit plans; potential to re-tender some lots. Mobilisation from April 2019 Thames Valley re-procuring 2 contracts, mobilisation from December 2019	Management of cost pressure due to transitional contracts for completion of treatment over a 2 year period	Greater equity in terms of waiting times for assessment and treatment Pathways in line with NHS England Commissioning Guide Reduction in secondary care referrals Contract KPIs
	Mandatory Dental Services (MDS) procurement KSS Q1 2020/21 Thames Valley – improving primary care access, addressing impact of population growth with procurement where required Wessex area - Procurement of MDS in Portsmouth, Alton and Tadley underway following termination of contracts. Mobilisation starting from June 2020. Temporary CVs to be issued for contracts previously allowed to over perform across Wessex. Plans to procure according to refreshed needs assessment. Aim for mobilisation starting from September 2020.	Stakeholder engagement Alignment of commissioning approach	Measurement of whole population access to MDS including areas of substantial population growth

National priorities 2019/20 -2023/24	Local Priorities	Strategic challenges	'Metrics'
Engagement - with patients, STPs, stakeholders & networks to ensure links with other services including Unscheduled Care/111 integration Market analysis Establishing baseline and service model of current service provision	Special Care Adults & Paediatrics – South East-wide procurement planning & preparation, incumbents extended to 2021. Procurement strategy and invitation to market late 2019	Needs assessment & engagement is complex. Agreeing baseline of current service Financial modelling Premises & equipment suitability Market interest and viability Workforce Sustainable pathways from level 1 to level 3 care for patients with additional needs	Measurement of most vulnerable patients having access to care Contract KPIs
	Unscheduled Dental Care KSS & Thames Valley procurement planning & preparation, extend incumbents to 2021 Wessex area –2 contracts in Dorset which are being extended until 31/03/22 and various GDS contracts across Wessex include urgent dental care. This is on the workplan to be reviewed but has not been commenced. The Dental Advice Service in established across Wessex and provided by SCAS.	Preparation for 2021 STP/ICS alignment & links with 111	Patients access dental care in appropriate timeframe rather than GP/A&E System supports patients to attend more regularly
	Sedation services KSS procurement planning & preparation, extend incumbents to 2021 Wessex area – sedation services being provided under 2 GDS contracts at present. Additional contracts may be required in the future depending on outcome of CDS procurement. Thames Valley	KSS Preparation for 2021 Achieving access across South-East for patients who do not meet Special Care criteria General Anaesthetic Services – scarcity of provision	'High Street' Sedation pathways in place across South-East Measure reduction in treatment under GA
	Minor Oral Surgery KSS procurement planning & preparation, expiry 2020 – potential to extend to 2021 Thames Valley – implement new arrangements post-procurement from April 2020 Wessex area – contract expire Oct 2021 with an option to extend for a further 12 months.	KSS Preparation for 2020 Pathways in place for treatment of less complex cases in out of hospital setting, reducing pressure on hospital services Thames Valley preparation for 2024	Consistent pathways in place across South-East with timely access to treatment Improved waiting time performance in hospitals
	Restorative Services: KSS procurement planning & preparation – expiry 2022 TV – implement new arrangements post-procurement from September 2019 Wessex area – Work has begun on a procurement for Level 2 and 3a Endo and Perio services across Wessex	KSS Preparation for 2022 Thames Valley preparation for 2024 Pathways in place for treatment of more complex Restorative cases that do not meet criteria for treatment in hospital	Measure reduction in secondary care activity NHS pathways available across South-East with timely access (TV, secondary care activity is for different cohort of patients)
	Dental Electronic Referral System (DERS) procurement Implement new arrangements from February 2020	Mobilisation by 2020 Streamlined referral process in line with NHS Digital	Primary care, tier 2 and hospital providers using DERS

National priorities 2019/20 -2023/24	Local Priorities	Strategic challenges	'Metrics'
	Wessex and Thames Valley: this will be awarded in October 2019 with a go live date of February 2020.	requirements to support more timely access of treatment	
Ensure all areas covered & supported by a number of managed clinical networks and delivering benefits	Strategic plan development/delivery (2018-23) & update on 2018/19 achievements All LDNS & MCNs reporting on their workplan and outcomes	Integrate & engage with STP/ICS governance and emerging Primary Care Networks (PCNs) to support place-based commissioning Commissioning team capacity to support initiatives	Workplan to ICS/STP & stakeholders Annual report

Figure 11

Chapter 4: A New Service Model for the 21st Century

This chapter sets out our transformational service changes in support of our core preventative approach alongside our need for radical change. In it, we set out the ambition and delivery plans for out of hospital care including primary and community care, primary care networks, urgent and emergency care and personalised care. Our ICPs set out their ambitions to locally deliver these priorities, based on our local population health needs.

Boosting 'out-of-hospital' care, integrating primary and community health services

By 2024, our System will have reduced the pressure on emergency services by implementing suitable, sustainable alternatives to urgent care in community care, primary care and empowering citizens to self-manage where appropriate to avoid use of emergency services. Our A&E departments will be able to maintain the national 4 hour access standards, patients will have timely discharge from hospital and where possible to home and emergency transport will be able to manage service demands with the support of the System.

We have a strong foundation of community care and primary care in Surrey Heartlands and expect visibly improved service integration into our communities over the next 5 years. This is often referred to as "out of hospital care" or "integrated care". By better integrating our care and services, we can interrupt the sequence of events that often lead to individuals in crisis, feeling without the right support with delays between services or discharge.

This integration will build on the ongoing work, which is forming proactive and preventative, rather than reactive responses to citizen's needs. Our continued work will take both proactive and reactive approaches including **short intervention care**, **support to care homes**, **community rapid response** (urgent community teams) and the transformation of **community support** by accelerating the development of multi professional and skilled teams through our Primary Care Networks (PCN) and Hubs.

Community Rapid Response
Our vision supports all local populations by bringing in the voluntary sector to embed joint resources to support individuals and those who have complex needs, receive the right care, in the right place, at the right time thereby reducing demand on our emergency services. We are developing community assistance technology (digital apps) to support the workforce whilst out in the community and expect to pilot 2019 between 2020.

Where Urgent Care is needed, we are continuing to build on the good work and areas of best practice already in place across Surrey Heartlands. Where care is sought through Urgent Treatment Centres, we will be testing the potential for 'GP streaming' (triage) and use of digital apps for the workforce across our System.

To support our System flow and improve patient experience, we are building on existing ambulatory emergency care work to reform the way patients are treated when they attend hospital as an emergency. Improvements in physiological practices mean (appropriate) patients no longer have to be admitted creating admission avoidance and reducing the number admitted, where needed. Our Same Day Emergency Care (SDEC) pathways form part of our annual System Resilience plan for winter, when greater amounts of emergency activity is seen and supports the overall ambition to manage and reduce pressures on emergency care. In parts of Surrey Heartlands where SCAS operate, we have

commissioned additional services for more ambulant patients to be transported home to support SDEC pathways.

Rapid Response and Reablement services
Rapid response and reablement services help to prevent admission and to enable effective, safe and timely discharges. Their role is vital to the flow of patients through both community and acute hospitals. Work has been underway to integrate the services there is work to do to achieve the level of integration and increase in capacity expected. Workforce and recruitment challenges are cited as impacting on the service.

The ambition is clear; there will be fully integrated teams delivering increased capacity, reducing bureaucracy releasing more time for staff to delivery rapid response and reablement services proactively and reactively. **By 2021, there will be parity of community health crisis response within 2 hours of referral and reablement care within 2 days of referral, where needed across Surrey Heartlands.**

We will continue to use the Better Care Fund (BCF) during its availability[14], to reduce delayed transfers of care and support the packages of care for citizens leaving hospital. Delivery of the BCF programmes of work such as reducing delayed transfers of care, improving integrated '7 day' service, improving the discharge to assess pathway and developments towards the 'trusted assessors' initiative, will continue to be reviewed by both adult social care and health providers within our ICPs. ICPs will continue the integration progression with these services and embed as part of the out of hospital developments and new models of care to realise the real potential and maximise impact.

Surrey Heartlands partners will work to build collaborative approaches to recruitment and retention of staff in this area and explore opportunities to develop a shared rapid response bank of staff who can be deployed at short notice to support Systems where there are early indications of deterioration in patient experience, flow and performance.

The ability to deliver all these advancements is supported by Surrey Heartlands' commitment to improving the data quality and usage of the Community Services minimum datasets to improve understanding of service use and population need. Over the past 18 months, significant investment has been made to build a robust business intelligence infrastructure to analyse and report our community datasets, which will ultimately feed into our plans for supporting population health management as well as contract monitoring and benchmarking our providers.

We have undertaken a review of the community data content to determine which fields have some of the poorest data quality issues. We are in the process of developing extensive data quality improvement plans (DQIPs) that we will jointly develop with our providers to support them on increasing the quality and effectiveness of the Community Minimum Datasets. As an ICS, we aspire to have one of the most robust community datasets for the entire country, given its significant importance in driving our population health management agenda.

Transforming Community Support
People in Surrey who have a severe mental illness are set to benefit from a ground-breaking new community mental health service designed to improve access to a wide range of specialist support.

Extended appointments with mental health experts from the NHS, social care and specialist third sector organisations, plus access to therapies, physical health checks and pharmacists, are just some of the wider expertise patients will be able to access at their local GP practice and in the community under new ways of working.

Patients will be able to explore the situation affecting their wellbeing; whether that is an ongoing mental or physical health problem, loneliness, debt, or other issues. They can then be guided to

[14] National review being undertaken during 2019

appropriate resources that may help, including talking therapies, benefits advice, or an introduction to a local community group.

Around 50% of those with severe mental illnesses, such as bipolar disorder, or major depression, currently see their GP to manage the majority of their care and treatment. Until now, this level of multi-agency support has mostly only been available to those referred to a specialist community mental health team.

Surrey Heartlands Health and Care Partnership has been **awarded £5.76m from a total of £70m set aside by NHS England to transform community mental health care in twelve 'early implementer' areas**. Mental health specialist, Surrey and Borders Partnership NHS Foundation Trust, will lead the local implementation over the next two years. The new funding will enable the Trust to expand upon field trials which have been running across three primary care networks (groups of GP practices working together) in Chertsey and Ottershaw, Banstead, and Guildford over the past six months.

This service, known locally as General Practice Integrated Mental Health Service (GPiMHs), is to be scaled up and extended across eight further sites across Surrey creating eleven in total. The service is intended to address the long standing health inequalities faced by people with severe mental illness. It is unacceptable that people with severe mental illness die around 20 years younger than average. This is often because of poor physical health and social factors, whilst smoking, drug or alcohol use, are also big influences.

By providing expert advice and support to local GP practices, we hope to reach more people, free up clinical time and help reduce the risk of people relapsing when their care is transferred back to their GP. The new service will help connect people with a wide range of local authority health and wellbeing support services from leisure facilities, clubs, groups, stop smoking advice to community transport. The plans also include expanding the specific support available for people with a personality disorder and developing more targeted support for young people aged 18 to 25 years. Services are expected to be in place by the end of March 2020, as part of a gradual roll-out and extensive recruitment campaign.

Primary Care networks focused on delivery at neighbourhood level

By March 2024, our ambition is that Primary Care Networks (PCN) will have stabilised the GP partnership model, helped resolve the capacity gap and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff, become a proven platform for further local NHS investment, including in premises, PCNs will dissolve the divide between primary, acute and community services, health and social care and mental and physical health services and achieved clear quantified impact for patients and the wider NHS.

A Primary Care Network (PCN) is not a new structure, a new organisation, or an NHS management tier. Instead, its core is simply an extension of the existing independent GP partnership model; collaborative provision. We will be continuing to building on existing good developmental work that has happened over the last two years in Surrey Heartlands.

Covering around 30-50,000 patients in a neighbourhood, the network is a group of separate GP practices coming together to address the challenges faced by general practice, with other community-based services to enable integration of care for patients. These networks will support the move away from managing just health to include care needs. In Surrey there are 120 GP practices organised in 24 Primary Care Networks. PCNs do not have hard boundaries therefore the map provided is based on where the majority of their patients live (figure12).

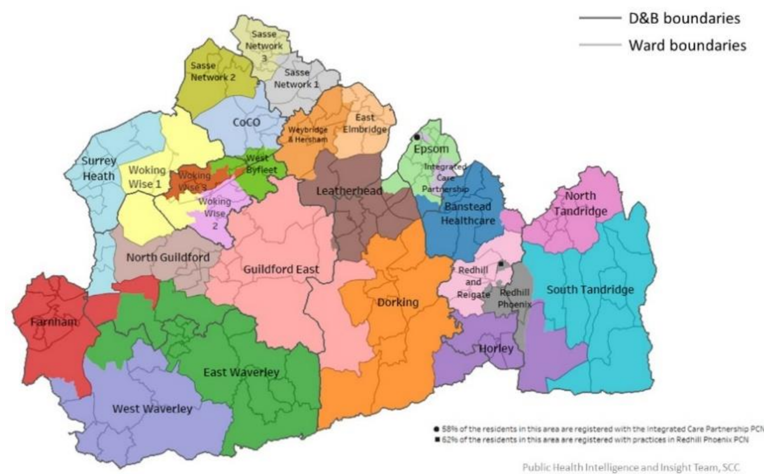


Figure 12

Our ambition for them is to underpin the move to integrate care around the citizen, support improved population health including prevention and health inequalities and positively impact on generational health by delivering services at the right level, by sharing expertise and workforce. This means by having good clinical leadership, which understands local needs and recognises the importance and role of the broader primary and community services, they will be well placed to enable people to live independently, live healthy and active lives, who do not feel isolated by having their wellbeing needs supported as part of a connected community of support. Supporting the shift to proactive care and support, we aim to reduce crisis interventions, such as emergency admissions and reduce the need for and travel to multiple appointments across services (see outpatient transformation).

How we will make this happen

Improved skill-mix: through our understanding of population health management and consequently the needs of the local population, we will drive the right skills into the areas of need. We will add or increase 5 new roles over the next 3 years to strengthen our skill-mix as part of national delivery requirements; first contact community paramedics, social prescribing link workers, clinical pharmacists, physician associates and first contact physiotherapy:

- Year1 (2019/20) social prescribing link workers and clinical pharmacists
- Year2 first contact physiotherapy & physician associates
- Year3 first contact community paramedic

Changing access: in addition to traditional ways of seeking advice, we will be implementing and extending digital access into general practice. During 2020, our citizens will be able to access their full medical records online and consult via an online platform. By 2021 video consultations will be available in all practices. We will be moving to no half day closures.

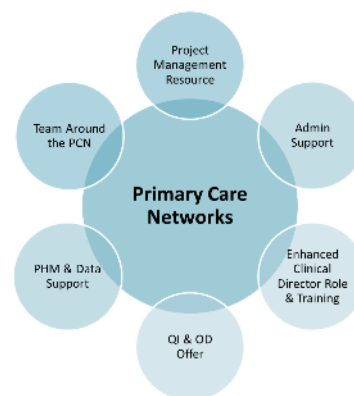
Developing our PCNs: we will be stabilising the GP Partnership model across Surrey Heartlands, through network support, there will be strong practices in each PCN.

Our PCN will deliver 7 nationally mandated service specifications over the next 3 years:

From April 2020	Structured Medications Reviews and Optimisation	PCN members will support direct tackling of the over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed and support medicines optimisation more widely.
	Enhanced Health in Care Homes	The aim of this service will be to enable all care homes to be supported by a consistent multi-disciplinary team of healthcare professionals, delivering proactive and reactive care.
	Anticipatory Care PCN	GP practices and other member providers will work collaboratively to introduce more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes, including patients receiving palliative care.
	Supporting Early Cancer Diagnosis	GP practices are likely to have a key role in helping ensure high and timely uptake of screening and case finding opportunities within their neighbourhoods. PCNs will have a key role in helping to ensure that all their GPs are using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.
	Personalised Care (as part of the NHS Comprehensive Model)	Six main evidence based components: • shared decision-making; • enabling choice (including legal rights to choice); • personalised care and support planning; • social 'prescribing' and community -based support; • supported self-management; and • personal health budgets and integrated personal budgets.
From April 2021	CVD Prevention and Diagnosis	PCNs will have a critical role in improving prevention, diagnosis and management of cardiovascular disease.
	Tackling Neighbourhood Inequalities	Good practice that can be adopted everywhere, tailored to reflect the specific context of PCN neighbourhoods.

Support offer to Primary Care Networks

Implementing the NHS Long Term Plan requires the development of effective Primary Care Networks. ICS Primary Care Leads are providing effective support to the PCN Clinical Directors and wider community partners to ensure delivery is achieved. The support in Surrey Heartlands includes:



- **Project Management Resource:** aligned dedicated capacity to support PCNs in delivery of service changes, pilot projects and contract implementation
- **Admin Support:** hosted support to PCNs to assist in coordinating PCN meetings a maximising capacity for PCN CDs
- **Enhanced Clinical Director Role:** CCG funded additional sessions to give PCNs time to interface with wider System partners. Provision of training and development.
- **Quality Improvement/Organisational Development Offer:** training and support in Quality Improvement methodologies and availability of facilitation to build relationships across the PCN
- **Population Health Management & Data Analytics:** a platform for collecting and analysing data relating to PCN population need and support in analysing and drawing conclusions for PCN members
- **Team Around the PCN:** work to reconfigure key services like district nursing and mental health services to work directly with PCN footprints on a day to day basis

PCN and Clinical Director Development

Each PCN has completed a 'development grid' to give them an understanding of where they are on their development progression. Using this baseline, the Maturity Matrix & Prospectus we are working with all 24 PCNs to plan their 'learning journey' over the next 5 years.

We understand that not all PCNs will be in the same position and will wish to build on different elements of the prospectus first. Therefore, the 2019/20 investment has been allocated directly to the PCNs.

The ICS supports the construction of a PCN level plan that outlines the areas they will undertake first to progress along the Maturity Matrix. Most PCNs measured their position on the Maturity Matrix

early and therefore the majority are at Foundation or Stage 1, but in reality, the PCNs have progressed rapidly since the appointment of their Clinical Directors since July 2019.

In terms of assurance the ICS, working with the PCNs to ensure we have an aggregated picture of:

- PCN Baseline positon
- Maturity Matrix position
- PCN 5 year development plans
- Service Delivery Areas
- Funding accountability

Same Day Access to GP appointments
GPs provide a range of booked and on the day access to their services. The number of on the day appointments released each day either through duty doctor sessions or other means is not counted such that the scope and scale of these services is known to partners and the population.

Surrey Heartlands will work with Practices and PCNs to establish robust ways of measuring the urgent care capacity and demand across primary care to better understand and plan across care pathways and improve access to services that are needed that same day as an alternative to Emergency Departments.

GPs, through the Federations across Surrey Heartlands provide booked and extended access to primary care services in the evenings and at weekend. During winter 2018, this saw 49,500 additional appointments. The new appointments have been well received and used with low 'did not attend' (DNA) rates. Between August 2018 and August 2019 on average 83% of appointments were booked; with the highest booked rate of 91% in North West Surrey and lowest of 70% in Guildford and Waverley. **By 2021, our citizens can expect parity of 'extended access', making services available between 8am and 8pm in primary care across Surrey Heartlands.**

GPs also work in acute hospitals either at the 'front door' streaming patients suitable for primary care assessment and intervention or via Urgent Treatment Centres (UTC) for example ASPH whereby all patients who are not an emergency are seen in the UTC. Our experience of such models is variable and as such, different models exist.

How we will make this happen:

- Maximise the utilisation of extended access appointments through publicity and communications exercises.
- Test and deploy innovative approaches to the provision of on the day urgent care appointments through use of everyday digital technology e.g. smart phones
- Review the existing models of GP streaming in acute trusts against best practice and develop a Surrey Heartlands model.

Primary Care GP Access
Surrey Heartlands has been working with local Federations to deliver General Practice Improved Access (GPIA). **Our System is successfully delivering this service to 100% of our population 7 days a week and are delivering 45 minutes of additional consultation capacity per 1,000 population**.

Our delivery model has proven effective, with each of the Federations being able to implement their own vision, with subtleties across geographic areas and demographics defining the types of services that worked in each area.

We have delivered an additional 97,000 appointments in the first year, 18,000 of which were delivered by video consultation. **The Family & Friends test conducted by each provider shows that 94% of patients deem the service to be good or excellent**. The data also shows that the utilisation of these appointments is generally very high.

Our ambition has been to utilise the learning from the GPIA to change the model at practice level. This includes the expansion of roles and skill mix, improving access via digital technology and integrating the wider community teams to wrap their services around the PCN as set out in figure 13.

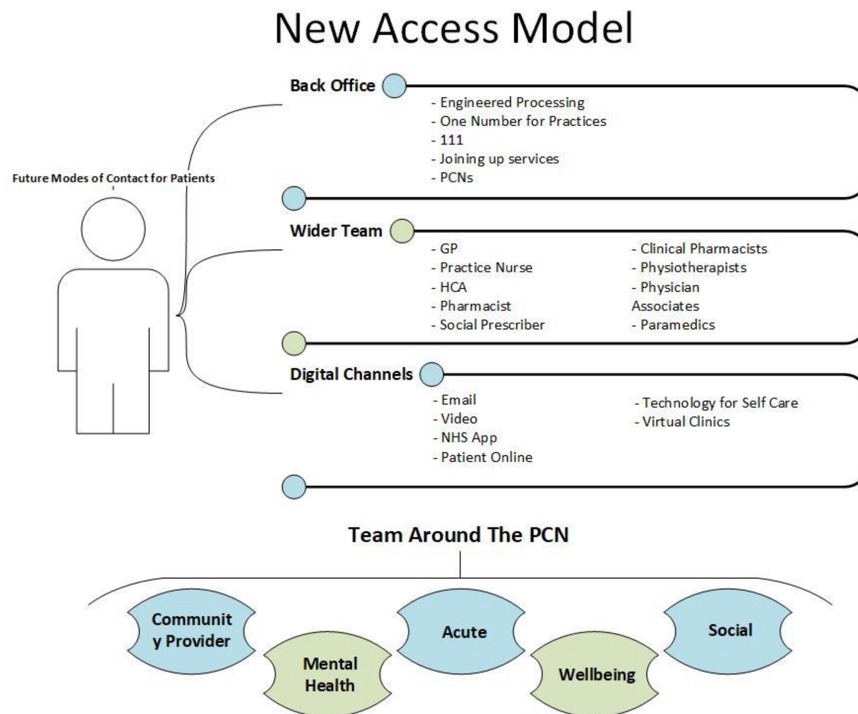


Figure 13

We have successfully modernised the 'modes of contact' available to patients using digital approaches including video consultations. **All member practices are enabled and ready to link with the 111 service to support System integration. By 2021, all our citizens will have uniformity of digital access; providing choice of access.**

Our ambition over the next 5 years to shift from the traditional delivery model to a digital front door as shown in figure 14.

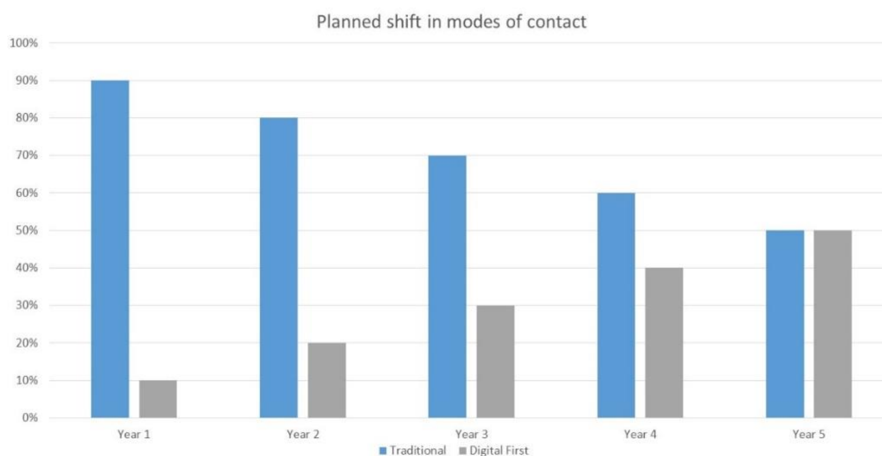


Figure 14

Support to Care Homes

By 2024, when in their home[15], our aging population will be able to receive heath and care support based on their need from a co-ordinated, multi discipline and skilled locally based team. The team's combined support will enable citizens to remain independent and proactively supported by the community through personalised care. Where urgent care or crisis arises, rapid community response will be in place and in the event of hospitalisation, citizens can expect their discharge to be based on the 'home first' principle to ensure their wellbeing and health outcomes are optimised.

Keeping individuals healthy and well is key to the proactive and preventative approach our PCN and hubs will be taking. Our aim is that our aging population will receive routine wellbeing checks to ensure their long term health conditions are managed medically and with appropriate care support around the individual creating personalised care.

Rates of older people still at home 91 days after discharge from hospital have increased. We aim to increase the percentage of older people still at home 91 days after discharge from hospital from our **current rate of 69.8% to 93%**. Emergency admission rates of these with dementia per 100,000 have decreased and **rates of deaths in usual place of residence has increased for those aged 65+; we plan to move from our current rate of 48.8%, to a 'best in class' rate of 55.7%.** The impact of these changes will see a **reduction in rate of emergency admissions of those with dementia** from our current position **of 3,379 per 100,000 population, to 2,496**.

Working with our citizens, we know that, given the choice, they would rather be in their homes* and evidence tells us that recovery is improved if they are enabled to do so. With this guide for our aging population, we will be seeking to ensure the "home first" principle is in place across our System by March 2024. This means, individuals will be returned home for further assessment then access intermediate care, rather than kept in hospital or other care facility whilst this happens. We will be looking to extend our 'discharge to assess' approach which is currently in place in our Guildford & Waverley patch as part of this development, short intervention care and the reduction of lengths of stay in hospital. Reduction in an individual's hospital length of stay is a significant factor to improving health outcomes and wellbeing to return to a healthy and well state. Our hospitals are working over the next year (2019/20) to reduce the number of length of stays in excess of 21 days. By getting this right, our citizens will be able to feel that they were better able to recover from their episode of ill-health. Our hospitals will additionally benefit from improved 'patient flow' and easing of emergency service pressure as a consequence.

Home for many can be a Care Home. In Surrey Heartlands, we are moving forward over the next three years to implement the national NHS programme, **Enhanced Health in Care Homes** (EHCH). This aims to improve the care of people in care homes by better coordination of existing services and by introducing enabling infrastructure (such as NHS secure email and medical advice & guidance). It is well documented that significant numbers of unplanned hospital activity from care homes does not result in an admission. By changing our behaviours with proactive & co-ordinated care, we expect to see a significant reduction in the number of emergency activity from care homes. Getting this right involves a number of partners such as; GP representatives, acute hospitals, community nurses, County Council and District & Borough councils, ambulance services, hospices, care home residents and Surrey Care Association.

We will make this happen by:

- Embedding a full System leadership and governance model incorporating board level Senior Responsible Officer's and clinical leads at ICS and ICP levels which embrace PCN directors.

[15] Usual place of residence

- Developing key infrastructure moves which will enable innovation and transformation in this arena both at scale and place. Piloting the outputs from the TIHM testbed in particular the clinical decision algorithms.
- Start-up's such as using machine learning and passive data capture devices to collect NEWS 2 information.
- Learning and quality improvement ecoSystem interventions
- Developing a prototype to explore the use of the ECHO (Extension for Community Healthcare Outcomes) to form learning communities of care homes, hospices and PCN's. This is a scalable approach which will enable trusted network to evolve and spread in a scalable way within both ICP and ICS geographies. These networks will enable QI and training to take place.
- Developing a local model for PCN support of care homes that builds on learning from strategic partnerships with good practice elsewhere.
- Support to all care home residents via bespoke whole System care home organisational support packages by May 2022.
- EHCH model rolled out across the whole county by April 2023; built on the implementation of the national Directly Enhanced service (DES) for EHCH within the GP contract.

This will be supported by:

- Full rollout of NHS mail and the NHS Data Security and Protection Tool (DSPT) by April 2021.
- Prototyping learning networks of care homes, hospices and PCN's using the Extension for Community Healthcare Outcomes (ECHO) model or similar by Dec 2021. This means providing upskilling opportunities for quality improvement competence and use of skills to share learning locally. If successful model will be rolled out across Surrey by April 2023.
- Technology enabled remote MDT consultations (video) to care home residents; building on existing pilots or similar by April 2023.
- Trial the RESTORE2 Model (Recognise early soft-signs Take observations, Respond, Escalate) by December 2020. This will enable collection of physiological information to automatically generate NESS2 scores thereby improving the care of deteriorating residents and preventing unnecessary admissions to other care settings. It will enable earlier treatment and recognition of UTI's and other clinical events. If successful phased rollout to all Surrey care homes by December 2023. As part of this trial and rollout we will incorporate technology enabled care approaches including those pioneered in Surrey as part of the Technology Integrated Health Management (TIHM) program. These technologies will enable non-invasive collection of health and care information that will support people care in real-time.

We expect citizens to see over the next 5 years:

- Consistent and high quality physical and mental health and care for the people who call care homes, "home"
- A care home workforce equipped and empowered to provide excellent care
- Citizens spending more time in their home because of increased wellbeing through reduced inappropriate trips to hospital.
- By receiving preventative treatments in their home e.g. early treatment of urinary tract infections
- By use of remote consultations from the community hubs and PCNs.
- Fewer adverse medication events and reduced pharmaceutical load
- Citizens dying in the place of their choice.

Pharmacy

*By March 2024, the development of a collaborative **pharmacy** workforce providing integrated pharmacy services to patients across Surrey Heartlands will ensure that we provide high quality medicines related care for those who need it, in the right place, at the right time, by the right person; work innovatively and in partnerships across our services to better serve the population and make Surrey Heartlands the best place to work (for the pharmacy workforce).*

Pharmacy and medicines optimisation is recognised as a key element for the successful delivery of the priorities identified in the long term plan (LTP). To enable the development of high quality pharmacy services across Surrey Heartlands to successfully deliver the priorities outlined within the LTP a priority area of workforce development has been identified. Work is being undertaken to create a sustainable and integrated workforce across all partner organisation with a change in mind set and culture moving away from the historical fragmented sector-based workforce. A pharmacy and medicines optimisation workforce strategy has been developed which identifies the following priority areas:

- Recruitment and retention
- Education and training
- Leadership development
- Integrated / specialist roles

Primary Care Network Clinical pharmacists: the LTP highlights the importance of pharmacists in delivering the ambitions outlined. PCNs over the next 5 years will be recruiting clinical pharmacists and work is being carried out in Surrey Heartlands to ensure these new roles are integrated within the wider workforce and that their roles are focused on improving patient outcomes in relation to medicines by:

- working as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients
- taking responsibility for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy
- providing specialist expertise in the use of medicines
- providing leadership on person centred medicines optimisation
- helping to conserve antibiotics in line with local antimicrobial stewardship guidance

Medicines Safety: the recruitment of a Surrey Heartlands Patient Safety Lead for Medicines to develop a culture across all Surrey Heartlands organisations to support “medication without harm” to reduce preventable hospital admissions relating to medicines and improved patient outcomes.

Transfer of Care Around Medicines (TCAM): Transfer of medicines information and pharmaceutical care when a patient is discharged from hospital can often be inefficient and inadequate with patients experiencing errors or unintentional changes to their medicines when they move between care providers. Work is being done across Surrey Heartlands to ensure a seamless transfer of medicines discharge information directly from hospital to the patient’s choice of Community Pharmacy which is anticipated to significantly lower rates of readmission and reduce the number of medication errors.

Pharmacist-led Information technology intervention for reducing Clinically Important Errors in medication management (PINCER): medication errors in primary and secondary care are a significant cause of morbidity and mortality with 1 in 20 items having an error. Work is underway in Surrey

Heartlands to roll out PINCER which is a pharmacist-led information technology intervention that has been shown to reduce clinically important errors in general practice prescribing.

Surrey care Record: work is being done to further improve communication with community pharmacies across Surrey Heartlands linking with the development of the Surrey Care Record (SyCR). It is anticipated that in 2020 community pharmacies will be enabled to view elements of the SyCR over and above what is currently available on the Summary Care Records (diagnosis, drug monitoring, pathology tests, discharge summaries) leading to improved patient safety (e.g. reduction in medication errors), more effective service (e.g. reducing patient need to visit another care setting, decreased waiting times) and improving the efficiency of care (e.g. reduction in number and duration of phone calls to the prescriber). Phase 2 of this project will include community pharmacies contributing clinical data (e.g. vaccination administration, minor illness consultation) to the SyCR.

Antimicrobial resistance: to develop a culture across all Surrey Heartlands organisations to support antimicrobial stewardship to reduce unwarranted variation in prescribing and improve prescribing standards. This work will include leading on all the medicines aspects of the UK 5 year antimicrobial resistance strategy with the development of a Surrey Heartlands antimicrobial formulary.

To enable this work to move forward a Surrey Heartlands wide pharmacy AMS group with appropriate membership from all partner organisations has been established to further optimise the use of antibiotics. This group links with the Surrey Heartlands AMR SRO, the Surrey Infection Prevention Committee and other partner organisations specific antimicrobial groups. The group has oversight of primary care antibiotic prescribing data / secondary care antibiotic prescribing data (CQUINs / volume) and other partner organisations antibiotic prescribing data; an escalation process to the Surrey Heartlands Quality and Performance Board has been agreed should any outliers be identified. The key KPIs being monitored currently are:

- Antibiotic volume in primary care: Increase number of practices meeting target (≤ 0.965 items)
- Antibiotic volume in secondary care: All providers to reduce consumption by 1% by March 2020
- UTI prescriptions in secondary care: All providers to achieve CQUIN target of 60-90% appropriate by March 2020
- Antibiotic prophylaxis in colorectal surgery: All providers to achieve CQUIN target of 60-90% appropriate by March 2020

The Surrey- wide Infection Prevention and Control Group described above has a membership from senior clinicians from a wide range of partner organisations including our independent providers and is led by the Surrey Heartlands Quality Directorate. This group meets regularly to identify learning around IPC (Infection Prevention and Control) practice and to share good practice. Application of this work is shared at subsequent meetings and ongoing practice is assured through business as usual process such as Clinical Quality Review Meetings and review of provider data.

A major focus of its work plan supports anti-microbial stewardship and a reduction in the incidence of Gram Negative Bloodstream Infections with the aim of meeting the ambitions set out by the Department of Health of a 25% reduction in England of the incidence by March 2021 and 50% by March 2024. The group reviews National Guidance such as the ongoing campaign to reduce the number of diagnostic urinary dipsticks that are used to diagnose a Urinary Tract Infection and promote evidence based practice across all providers and supports implementation locally promoting a consistent approach to both delivery and monitoring of quality impacts for patients through local forums such as Care Home Forums and Surrey Heartlands wide data and soft intelligence.

Care Homes: working to develop an expert pharmacy team to improve the quality of care for residents in care homes through better medicines use. This work will reduce the risk of harm from medicines in care homes through medicines optimisation and safer medicines Systems and staff training whilst

providing care home residents with equity of access to a clinical pharmacist as a member of a multidisciplinary team in order to achieve medicines optimisation according to need.

Community Pharmacy: Contractual Framework has been released to support the delivery of the LTP. Work is being undertaken across Surrey Heartlands to maximise referrals to the new NHS Community Pharmacist Consultation Service (CPCS) which will relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet the needs of the patients. The framework also requires pharmacies in a PCN area to have a collaborative approach to engaging with their PCN including the appointment of a lead representative and we are working across Surrey Heartlands to maximise the effectiveness of this engagement and collaboration.

To build on this engagement we are looking to progress a walk in my shoes project which will allow staff from GP practices to visit community pharmacies and vice versa in order to give GP teams and pharmacy teams the opportunity to experience life in primary care from a different perspective, and to learn with and from each other to build relationships, improve Systems and identify solutions together.

To support patients around their management of respiratory disease and use of inhalers work is underway linking community pharmacies with PCNs to help support this cohort of patients in relation to: educating patients on the correct use of inhalers, support patients to reduce the use of short acting bronchodilator inhalers, support the uptake of new smart inhalers and switch to dry powder inhalers where clinically appropriate

Acute Trust: work is underway across Surrey Heartlands in relation to implementing an electronic Prescribing and Medicines Administration (ePMA) / electronic patient record (EPR) solution within the Acute Trusts. This work involves maximising the inter-operability functions of the new System to improve medicines safety. The Acute Trust pharmacy leaders are also working collaboratively to explore possibilities around new ways of working to maximise efficiencies.

Data: work is underway in producing a single set of pharmacy and medicines optimisation data that can be utilised across the System (ICS / ICPs / PCNs / practices) to support targeted interventions to maximise the impact of interventions made by the pharmacy workforce.

Reducing pressure on emergency hospital services

Surrey Heartlands has seen increased attendances at Emergency Departments with around 4% annual growth, which has resulted in **reduced performance against the 95% 4 hour wait**.

This is against a backdrop of increased access to primary care through extended hours appointments and appointments at weekend being available and being booked and also through trialling skype/video consultations. Additionally, the System has reduced the long length of stay patients (over 21 days) to improve patient flow and ensure patients only stay in hospital when they need to be there.

Surrey Heartlands has an ambition not only to meet the '4 hour standard' but to reduce demand in Emergency Departments by building out of hospital services through partnership working that provide access to urgent care services on the day, every day at a place accessible to our citizens. This work includes reducing avoidance conveyances to emergency departments by ambulance.

Our ambition is to sustainably achieve Ambulance Response Standards (ARP) through a range of measures including an active recruitment programme of qualified paramedics and Emergency Care Support Workers, reducing Job Cycle Time, handover delays, investment on fleet, increased clinical support in the Emergency Operations Centre.

Although our trajectories for ambulance conveyance to emergency departments is shown to increase over the next 5 years, the proportion of total emergency incidents that are conveyed reduces over the period reflecting the shift in treatment management by ambulance staff (figure 15). The proportion of 'hear and treat' and 'see and treat' will continue to increase to support reduce pressure on emergency departments.

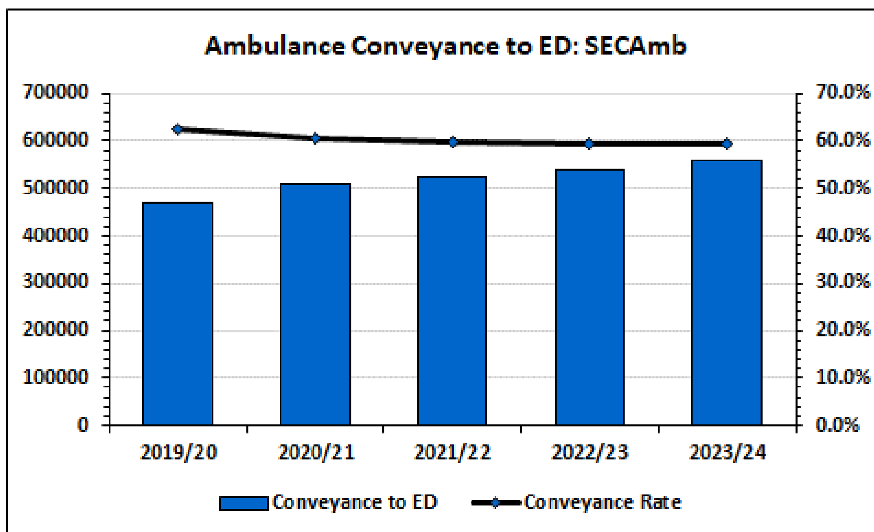


Figure 15

SECAmb are continuing to undertake joint live 'front door' reviews to ensure they are optimising community pathways where they are available such as ambulatory care, maternity, SAU, community falls service, OOH and MIU. Each year, partners agree the ambition levels for conveyance and revise annually to stretch improvement. For 2019/20, SECAmb aim to manage 10% of activity as 'Hear and Treat', 33.5% as 'See and Treat', 55% 'see and convey to emergency department' and a further 1.5% through other conveyance. Following a successful pilot which found crew on scene had improved ability to identify care locations closer to patients' home, SECAmb are ready to roll out 'NHS Service Finder'. This tool is also designed to help facilitate conversations between Health Care Professionals and Care partners and thus reduce avoidable conveyances to A&E. System Partners are further working to develop additional hospital alternatives in the east of our geography.

Handover delays have remained relatively stable and the majority of acute Trusts have seen some improvement. Further work is being undertaken with regards to managing surges effectively (relatively high number of calls received and queueing ambulances). We know there are different processes and pathways in place at the individual sites which can impact delivery. Partners are continuing to enhance and develop Operational Readiness Action Plans, which face persistent challenge of recruitment and retention, efficient use of fleet, operational facilities and reduction of handover delays.

Building on the work already in place, the Ambulance Handover Delays Steering Group made up of partners from SECAmb, CCG's, NHSE/I and Trusts, provides governance and local awareness to drive the improvement work required to reduce hours lost as a result of handover delays.

Each Integrated Care Partnership has developed and is delivering plans to transform out of hospital services to deliver increased access and reduce attendances at Emergency Departments, releasing them to focus on the most acutely ill.

Surrey Heartlands will adopt the new emergency standards currently being piloted and will prepare for this across the System to ensure that when a person does attend ED that they are assessed and treated within the new evidence based timeframes such that waiting times and patient experience improves as well as outcomes.

We have in place an Integrated Urgent Care (111) Directory of Services and are seeking to further utilise and strengthen quality. By March 2020, we expect to reduce the use of 'A&E by default' to <1%. We will deliver an increase in clinical triage (clinical assessment service) of calls as part of the IUC, which is being developed with primary care and through the 'Better Care Together' programme. Our workforce and citizens will see a change in their care destination by ensuring right care, in the right place, at the right time to respond to the urgent need.

As part of our IUC, we are developing plans for Urgent Care Centres (or Urgent Treatment Centres). Our *Big Picture* and *Better Care Together* urgent care programmes are seeking to create option developments for how we provide urgent care services in North West Surrey and Guildford & Waverley, taking into account new national guidance on Urgent Treatment Centres. You can read more about these engagement programme on our NWS and G&W websites.

Delayed Transfers of Care
Behind every delayed transfer of care from hospital, there is a person, in the wrong place at the wrong time. We want to improve services for citizens by reducing situations where people are in hospital longer than they need to be, which has a detrimental effect on their recovery, rehabilitation and long-term health and well-being. We know this may be particularly problematic for people who are frail or have long-term care and support needs. By counting the number of delays, we can better understand where the System is not working as well as it could and implement actions to expedite the discharge from hospital. We use 'real time' reporting between partners to support local decision making to ensure appropriate mitigating actions are taken as part of regular System Management calls.

Surrey Heartlands has seen a reduction in hospital stays of over 21 days during 2018/19; however, this was below the national ambition to reduce these by 25% compared to previous year. For 2019/20 the ambition has been stretched to 40% reduction, to ensure capacity is increased to cope with demand, particularly over the winter period. Each ICP has plans in place to achieve the national ambition and progress is assured via the A&E Delivery Boards.

The following table describes the 'high impact changes' that support managing emergency pressure across our System.

High Impact Change	Rating	Progress
Early discharge planning	Established	Each area has plans in place to support early discharge once the patient is ready to leave the acute hospital; East Surrey have dedicated home based care in place, along with joint leadership roles across health and social care to support the CHC Discharge to Assess (D2A) process; with additional resource being commissioned within the community. Both SaSH and RSH have programmes in place to actively promote discharge planning so patients are not delayed in leaving the hospitals; SaSH programme is entitled 'Let's Get You Home' and RSH 'One Home Today' – which also supports patients in getting up and dressed when able and as soon as possible during the person's hospital stay – this all assists with supporting timely discharge. In NWS and Surrey Downs, a focus on increased access via the Locality Hubs is being developed, along with closer working with the Primary Care Networks. All areas are improving their response and service to those people who have experienced a fall. Also in NWS, Community Hospitals are prototyping the use of GPs on the wards which is supporting discharge; a new role of Clinical Care Co-ordinator based at the acute has also been introduced to identify patients that may require further support within the Community hospital earlier; along with integrating In-reach matrons, social care and therapist in A&E to create a '# one team' approach providing alternative pathways to admission.

High Impact Change	Rating	Progress
Systems to monitor flow	Mature	All areas are supporting flow by having senior representation from all system partners working with the collective aim of identifying and delivering the required actions to improve flow, maximise discharges, reduce the number of patients with extended length of stay, identify and manage any challenges and risks. Each area has also increased their oversight of system flow via data platforms which provide numerical information and support the multi-agency system calls, when they are required. The set of metrics within the data platform is able to inform the systems where the pressures are being experienced and where there is capacity; this then assists and supports decision making in relation to focused interventions which supports de-escalation.
MDT Discharge Teams	established	Across Surrey Heartlands there has been further work in ensuring that as many people as possible are able to have their CHC assessments completed outside of the hospital environment; along with joint working with voluntary groups and the local District and Borough Councils. Each area continues to promote inter-disciplinary and cross agency working which supports communication and in ensuring that post discharge arrangements are in place with fewer delays. This is further supported by daily multi-disciplinary meetings and daily system calls (as required), which will continue throughout winter to maintain focus on system flow. One approach also includes 'walking the floor', undertaking joint Community and ASC visits to each ward.
Home First - Discharge to Assess (D2A)	Established	Increasing numbers of people, who would have normally stayed in hospital for longer, are now receiving care at home; by bringing together the different agencies, all with an emphasis on getting people home, rather than transferring to Residential Care has ensured that the Delayed Transfer of Care figures have generally remained below the NHS target of 3.5%.
Seven Day service	Established	Each area has improved their 7-day working, for example, Adult Social care are providing assessments and support with discharges at the weekends, with the numbers of weekend discharges now increasing. In previous winter periods, investment has been made into providing extra home care support to ensure people are able to return home as soon as they are able. Work is being undertaken so that SECAmb are able to have direct access to 'step up' beds within the Community Hospital in NWS. However, more can be done to discharge people from the Acute hospitals at weekends. Number of discharges to the community each day has consistently increased however is not in line with demand. Opportunities for improvement include developing the following: - • Criteria led discharge • 7 day working by all teams • Increased number of weekend transfers to residential and nursing homes
Trusted Assessors	Plans in place	Trusted Assessment is when one agency 'trusts' another agency to complete an assessment - this agreement is for pre-agreed access to certain services and is generally used when patients are transferring into short term or Intermediate Care services on discharge from hospital. Each area has committed to continue to expand trusted assessment processes between acute and community based services; potentially with a single assessment form which in turn supports an integrated care model, again leading to increased numbers of discharges.
Focus on Choice	Mature	Increased focus on choice and providing better information for example via the East Surrey Wellbeing Advisor service which is now fully implemented to support discharges; has also supported the low numbers of delays attributed to patient choice. Work continues in providing more information to patients and their families earlier in the persons stay in both Acute and Community hospitals.

You can read more about our emergency services seasonal planning in appendix 9.

Personalising and Owning Care

Personalised Care seeks to support people to stay well, to make informed decisions and to build confidence to make choices regarding their health and care. The NHS England and NHS Improvement 'Comprehensive Model' outlines the approach to support populations (figure 16).

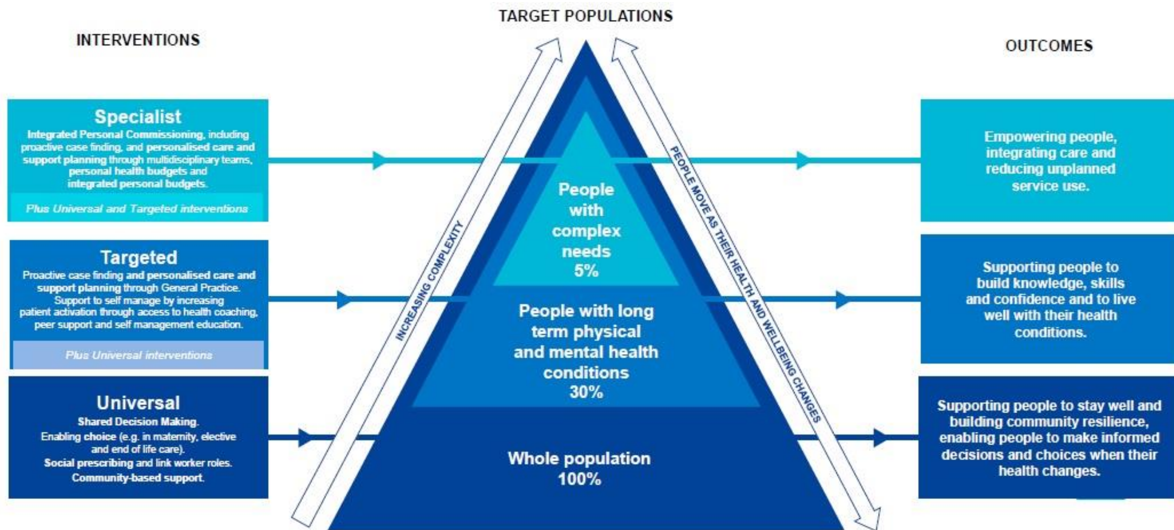


Figure 16

In practice, personalised care takes place in a range of settings and in a variety of ways; throughout this document you will find our personalised care commitments. NHS England and NHS Improvement's operating model provides a high level overview of how this works (figure 17).

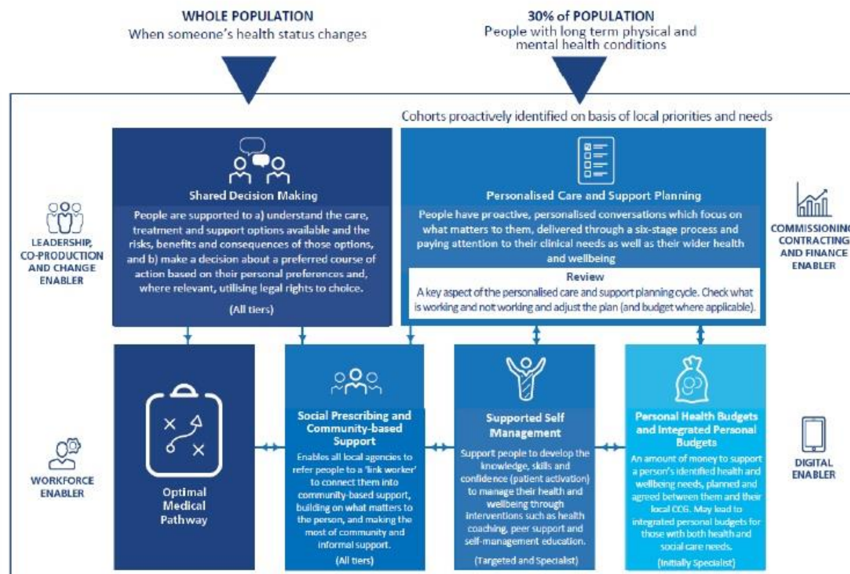


Figure 17

In Surrey Heartlands, personalised care is already adopted in a number of clinical areas such as maternity, cancer, diabetes, dementia, planned care, children's services and all age mental health. Social prescribing forms part of our primary care and community based prevention and self-management support and is incorporated into key life phases such as end of life care.

We have ambitious trajectories to improve personalised care within Surrey Heartlands. The table in figure 18 shows how we contribute to the national ambition for 2.5million people by 2023/24 to benefit from personalised care.

Year		19/20		20/21		21/22		22/23		23/24	
SP Link workers		23		39		54		69		83	
Social Prescribing		1,052		4,208		8,415		12,623		16,831	
Patient Activated Measures		2,104		4,208		7,364		11,571		15,779	
personalised care and support plan		3,072		4,514		8,515		13,677		18,521	
Personal Health Budgets		740		1,433		2,126		2,819		3,515	
Workforce	Primary care	83		278	181	417	271	487	243	209	104
	Secondary care				97		146		243		104

Figure 18: 'Comprehensive Model' outcomes

Shared Decision Making

Shared decision making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment. The conversation brings together the clinician's expertise, such as treatment options, evidence, risks and benefits and what the patient knows best: their preferences, personal circumstances, goals, values and beliefs. You can find out more about shared decision making, why it's important and how you can make it happen through the NHS England website.

Making Every Contact Count

This is an evidence-based approach to improving people's health and wellbeing by helping them change their behaviour. The Making Every Contact Count (MECC) approach enables our health and care workers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing. In Surrey Heartlands, our front line workforce is receiving training to support our citizens with increasing awareness and the range of options available to them. The MECC approach is intrinsically linked with our social prescribing work and expanded across primary care. Similarly, Surrey County Council has also adopted motivational interviewing to help and support behaviour change for their clients in children's services.

Self-care

Following a recent review, the Healthy Surrey website is being developed to be the 'go to' place for information about health and wellbeing in Surrey. It provides a platform for residents to find self-care sources and local service information to lead a healthy lifestyle. It also provides a useful digital tool for professionals to promote key health messages and signpost residents to local and national services.

Personal Health Budgets

Currently, Surrey Heartlands performs poorly in the provision of PHBs; this is driven by low numbers of PHBs for people with a long term condition. Our Continuing Health Care PHBs are growing and we will continue to expand year on year to ensure personal budgets are fully embedded to assess how best to meet the needs of individuals. **Surrey Heartlands will, as a minimum, more than double the use of Personal Health Budgets, in line with the Long Term Plan trajectory by 2023/24** (figure 19)**.**

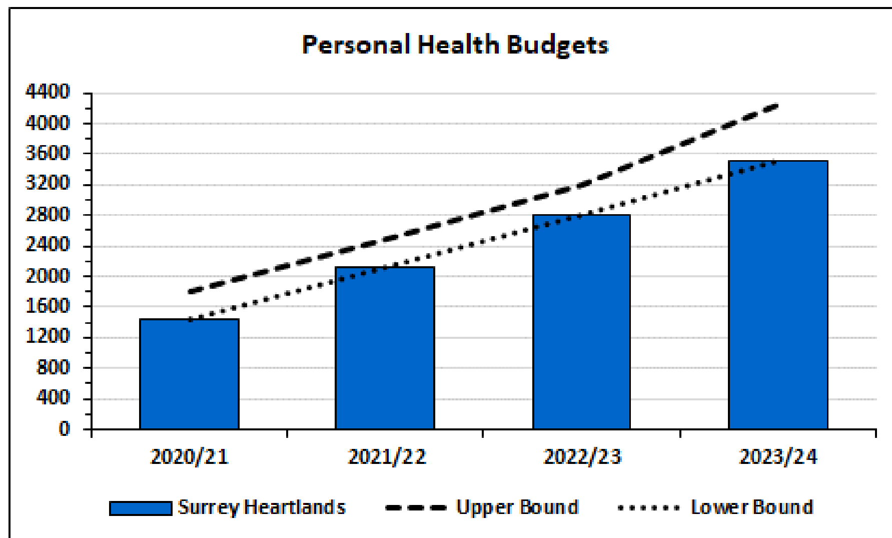


Figure 19

We will achieve this through a number of specific actions to both incrementally improve access to PHBs through existing routes and expand personalised care through new avenues, to new cohorts of people.

Mental Health & Learning Disabilities
We recognise that PHBs are a particularly powerful way of providing individualised support for people with complex mental health needs and learning disabilities. We already put PHBs in place for this patient cohort, but our data systems do not capture this. We will improve our data capture and ensure that the number of mental health and LD patients offered PHBs increases year on year.

Wheelchair Personal Budgets
Through our new Wheelchair service, coming online in 2020/21, we will introduce personal wheelchair budgets for the first time, delivering individualised mobility support to the people of Surrey Heartlands. This will expand the use of Personal Health Budgets out to an entirely new cohort of people.

Flexible Deployment of PHBs for Long Term Conditions
We will seek to create flexible financial systems that will allow personal health budgets to be deployed for people with Long Term Conditions or with complex long term care needs. This will continue to expand the use of PHBs to wider cohorts and ensure support is holistic and individualised.

Children and Young People
Surrey recognises the potential of personalisation to support CYP referred into clinical CAMHS, awaiting assessment or treatment. The ability to offer mental health personal health budgets (PHBs) would both help manage demand for providers' services and enable:

- A recovery-focused approach to mental health services, moving beyond treatment
- Children and young people able to define their own outcomes and design their own packages of care and support resulting in greater self-management
- Greater choice, flexibility and control over their health care

Surrey currently provides PHBs for children with complex and continuing health care needs and learning disabilities. It is our intention to use the existing infrastructure to expand our PHB offer to include mental health, aligned to our direction of travel set out in EWMH Transformation Programme; particularly focusing on our vulnerable groups of CYP. The PHB pilot is expected to commence in

2019/20, with a focus on looked-after CYP who are hard to engage, particularly within the CAMH Children in Care, 3Cs and HOPE services. Figure 20 describes the improvement focus and implementation period.

Strategic approach	Summary Recommendation for Continuous Improvement	Short (30-90 days) Medium (90-180 days) Long term
Driving up quality outcomes and experience – Patient and Family	• Evaluating the patient experience end to end and in service provision • Managing expectations for better experience - CHC Relationship Management across provider services • Transition services -strengthening the Transition pathway with Local Authority and Children's CHC, investing in designated resources	• Short to long term • Short to long term • Short to long term
Optimising Workforce Development and Leadership	• Network locally and regionally with partners for consistency of application of NF and decision making Stakeholder engagement management role in development with schedule of workshops/events. • Performance - CHC Competency Framework. Establish standards for behaviours and competencies development across team. • Resilience – CHC Associate Practitioner Apprenticeship Scheme to strengthen workforce into future. • Regional training, events and peer review • Surrey 500 Leadership participation	• Short term • Short term • Medium term • Short/medium term • Short to long term
Ensuring Value for money	• End to end paperless process to improve efficiency	• Medium to long term
Improving Integration and developing partners	• Proactive market management and joint commissioning of care with local authority and other partners. Joint commissioning forum and events for Home based care.	• Short term to long term
Strengthen leadership and robust governance	• Geographic specific Strategic Commissioning plan - Surrey CHC to move to Surrey Wide Services Directorate with Health and Social Care. Anticipate that further development of commissioning plans will be subject to finalising this arrangement • In team shared leadership approach through 'CHC Senior Leadership Team' impact still to be evaluated. • Governance across end to end CHC process – CHC Board Joint Chair – Health and Social care. Assurance of Operations management. Action: Review and update CHC Operating Policy	• Short to medium term • Medium term • Short term

Figure 20

Aging Well

Surrey Heartlands is committed to supporting people age well. A significant amount of this support is received in the community via Primary Care Networks and community services including rapid community response, EHCH, community teams and social prescribing. Our ambition over the next 5 years is to make the shift to citizens aging well with the support they need around them (figure 21). From 2020/21, our Primary Care Networks will be assessing their populations to provide targeted support.

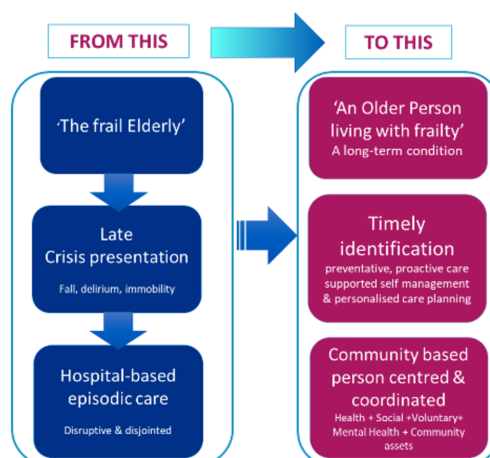


Figure 21

End of Life

In Surrey Heartlands, 2019/20 is a key year for accelerating the development of personalised care to improve end of life care. A new emergency care plan has been developed in the UK to support conversations and record recommendations arising from discussion between clinician and patient or those close to the patient. The ReSPECT form records recommendations to guide decision-making in an emergency, including decisions about CPR. Applicable to all ages, in all care settings, the form will be used across hospitals, hospices, community, care homes and ambulance services. It compliments more detailed advance care plans already in existence, by providing a summary for use in an emergency. The ReSPECT process is already in use and will be expanded across Surrey Heartlands by 2022.

Over the next 5 years, we will see the development of a robust, integrated, preventative Intermediate Care offer to help people to live independently and die well; using the Better Care Fund to engage with wider partners and develop System-wide services to develop the offer. We have introduced a 'Surrey End of Life group' which has the responsibility to ensure better support to everyone in Surrey as they approach end of life including their families by 2023; including their last year of life as part of personalised care; supported by the Health and Wellbeing strategy. A specific work programme with deliverables will be developed in 2020 which incorporates the ReSPECT approach and the Proactive Anticipatory Care Planning (PACe) already in place in Guildford & Waverley ICP, supporting people in their last year. PACe rollout across Surrey Heartlands will be scoped during 2020.

Dementia

Building on the Surrey Heartlands Dementia Strategy, we will develop integrated, countywide response for people living with Dementia and utilise the developing Technology Enabled Care service. We plan to increase the percentage of people with a diagnosis of dementia on GP registers from our **current position of 65.2% to 70%.**

We will undertake a range of activities supporting personalised care such as:

- Integration of CMHT-OP into community services/frailty hubs (using Bedser Hub model as examples of good/award winning practice). Through the service diagnose dementia and provide cognitive stimulation therapy for all in whom it has been identified that it could help by April 2022
- Increase provision of carer support courses - ensure carers of people with dementia support courses are available for all in Surrey Heartlands (e.g. expand the CriSP course provision that is currently available sporadically across Surrey) by April 2023
- Pilot (with a view to full roll out across SH if pilot is successful) an advanced dementia support service in one locality or PCN for example an Admiral nurse based in community services home visiting and providing care coordination for people with advanced dementia- supporting those with BPSD symptoms, and linking with community hospice to improve palliative care support for the last year of life in Dementia by April 2021
- Provision of a community delirium pathway across Surrey Heartlands using integrated CMHT-OP/community services to follow up and manage delirium in the community by April 2022

We will know this has happened when people live independently at home for as long as possible, people receive joined-up, person-centred services and only need to tell their story once and people are supported to manage their own health and care.

Continuing Healthcare

*By March 2024, Surrey **Continuing Health Care (CHC)** will be operating at scale through Integrated Care Partnerships across the Surrey geography for Better Outcomes, Better Experience and Better Use of Resources.*

Over the next 5 years, we have a number of strategic drivers to transform the way we facilitate the package of care for people who are assessed as having significant ongoing healthcare needs:

- Driving up quality outcomes and patient experience by the effective provision of long term support across Health and Social Care
- Optimising workforce to deliver operational excellence by supporting continuous professional development and clinical consistency through standardisation of competencies and peer to peer learning with local, regional and national CHC initiatives
- Ensuring value for money by continuous improvement, research and development through engagement and development for improved ways of working with local, regional and national CHC initiatives by proactive market management.
- Improving integration and developing partners by exploring the potential to integrate the CHC function with Social Care in Surrey for pooling of budget and contracts to allow for shared workforce and resource.
- Strengthen leadership and robust governance across the CHC service and at an ICS and ICP level by adapting to System changes by strategic leadership and operational management across the end to end process.

Figure 22 shows how the System will enable person centred for CHC.

Figure 22

We will continue to work with a range of partners including NHS England, CHC Digital SIP Programme, Residential Nursing Homes, Home Based Care Providers and the Local Authority to deliver the ambition.

We expect citizens to see over the next 5 years:

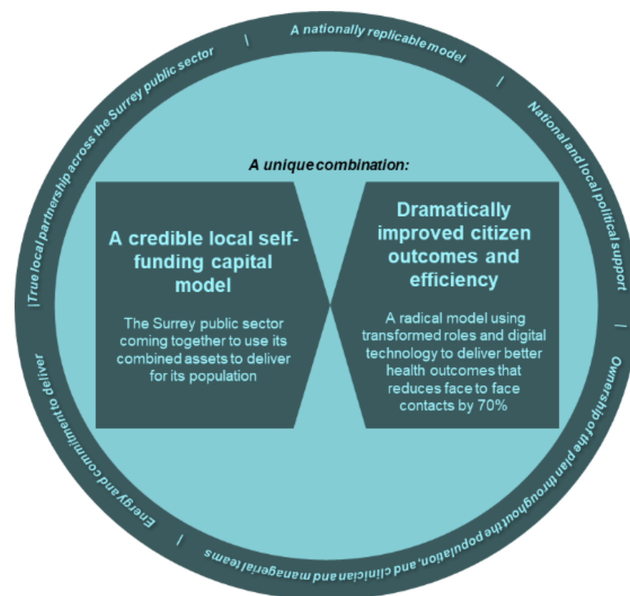
- Most decisions made within 28 day
- Improved pathways for CHC assessments
- Increased numbers of people benefiting from integrated services

Transforming primary and outpatient care

Our ambition is to create an integrated care model for delivering preventative, diagnostic and managed care services, with an increasing focus on citizen partnership and self-care management, underpinned by a fresh recognition of the wider determinants of health and prevention. As an integrated care system, with NHS people working hand in hand with our Council colleagues we are uniquely placed to deliver a transformed care experience for the citizens of Surrey.

By March 2024 through deploying digital solutions consistently and at scale, our population will be able to access health and care support in greater convenience and closer to home. Our population will benefit from greater utilisation of preventative services and support, health screening and accessible diagnostics to lead healthier lives. There will be stronger communities of support across all the key determinants of health and wellbeing, including clinical experts enabling greater ability to manage own health and wellbeing. Our citizens and care professionals will be digitally connected. Outpatients attendances where required will provide the highest quality care.

We recognise the need for radical change across the region to enable key components of the new service model. Through considering our citizens and their communities, our workforce, core processes and the technology that is available; by respecting the value of each other's time and resources, and through learning together and from others, we can make a difference to the health and wellbeing of our population.



Our intent is to reduce the environmental impact of our services, responding to the estimated 5% accountability for generation of air pollution and traffic on the local area due to NHS related road traffic in England each day (www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/travel.aspx).

To effectively manage resources and reduce the demands on direct clinical expertise we will collaborate with organisations outside the NHS to develop integrated services and maximise the use of digital technologies that can best serve the needs of the local population.

A way forward: We recognise that there are key factors that must be addressed within the Surrey Heartlands area to make a radical difference to citizen wellbeing and health care, and to reduce the need for patients to access a range of diagnostic and managed care services, including 'outpatient' services.

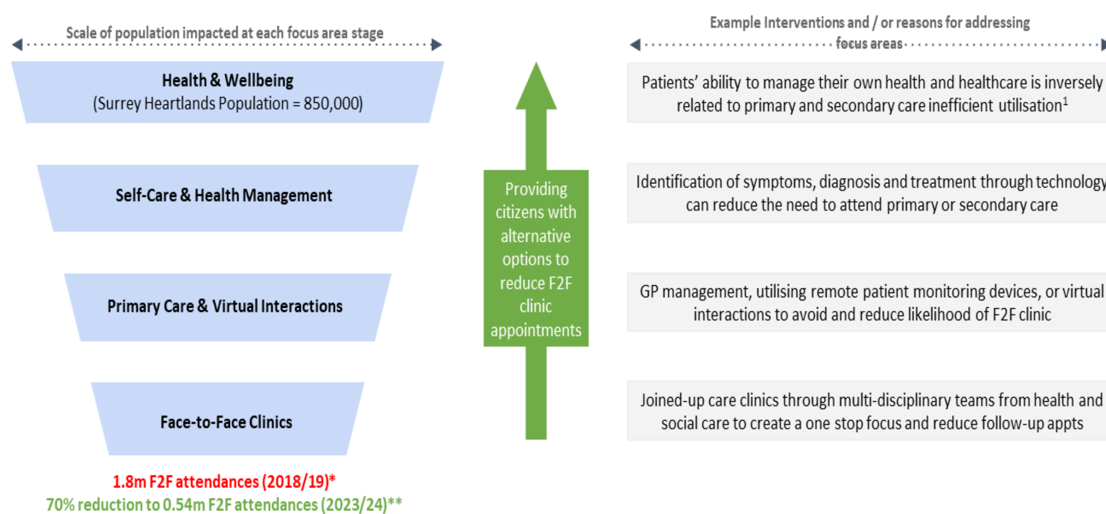
Helping and enabling people to stay healthy: Understanding population health management, utilising prevention techniques, screening facilities and providing easily accessible diagnostics, working collaboratively with all providers of services associated with the wider determinants of health and wellbeing.

Helping and enabling people to manage their own health and wellbeing: Using accessible resources and assets, defined as the 'asset based approach' and supported by digital access to information and support developed in collaboration with clinical experts and local health and wellbeing service providers.

Connecting people through digital technology: Providing access to advice and information that citizens and patients require without having to travel. Connecting people to trained professionals, virtual clinicians and care providers, and digitally enabled services which can automate and direct people to best suited options.

Delivering high quality face-to-face interactions: Where patients are required to attend outpatient appointments, we will ensure that the appointments are of the highest quality (i.e. if people have to trave,l we ensure they receive all the face-to-face support they require in one visit; right place, right time, right care or support.

We have identified four focus areas, and are considering the scale of the population at each, and appropriate associated interventions, for example:



Using our **'Planned Care Principles'** we will co-design our approach with the citizens and system wide-stakeholders to focus on the following areas:

- **Empowered to self-care:** through easy access to good quality information and support
- **Technology:** utilise available technology to reduce unnecessary delays
- **Emotional support & wellbeing:** readily available through voluntary and local partners
- **Patient choice:** respect citizens through offering different options wherever possible
- **Specialist practitioner**: access available in the community with clear referral routes
- **Patient navigators:** for complex conditions where multiple specialties can support
- **Alternatives:** appointments should be offered when needed with alternatives available
- **Shared decision-making:** empowered and informed options and decisions with patients
- **Improving access:** reduction in access inequalities for vulnerable and high risk patients

Our initial focus is to:

- Transform our outpatient services, supporting patients to self-manage their own care where appropriate, providing access to real time condition management advice and rapid access to specialist opinions in ways that value both citizen and specialist time, minimise our environmental footprint and create time for more comprehensive wellbeing support for population cohorts who most need our services. **Reduce our outpatient face to face appointments by 70% by 2024.**
- Develop at pace and scale, solutions tried and tested with our citizens to integrate technology, health outcome data and artificial intelligence into providing smarter more responsive, person centred services; making best use of the enabling ambitions of our digital transformation and workforce strategy.
- Work with all our partners, including the Surrey Heartlands Academy, external stakeholders including the Royal College of Physicians and established innovators including the national network of AHSNs, Nesta and organisations supporting social impact and community engagement to develop and share solutions, including drawing upon the learning and experience of other sectors and industries that have faced similar challenges.

Workforce Engagement: System-level changes to our care models will impact the current workforce providing health and wellbeing services in Surrey, in our organisations and those of our partners, as well as the skills and behaviours of future colleagues. Our workforce strategy, plans and redesign aspirations will be key enablers of our transformed care model, as will the role of our Academy and associated innovation and learning partners. Engagement and co-design with our workforce and citizens over our future services will be key to their efficiency, sustainability and outcomes.

Citizen engagement: Surrey Heartlands has a well-established approach to citizen engagement recognised as best practice among ICSs. Our programme will use the resources we have developed including: our citizens panel; our citizens ambassadors; and co-design approach. This builds on an approach already used successfully within Adult Social Care, harnessing the strengths of individuals and communities by creating the conditions for community assets to thrive, removing barriers and for health and care services to work alongside communities in ways that are empowering, engaging and meaningful. Our intent is to create the conditions for effective social action across our communities and enabling greater levels of collective control in order that local people can improve their own wellbeing and ultimately reduce inequalities.

Digital Capabilities: A range of technologies currently exist in the region, maximising and scaling-up solutions which are delivering benefits will need to be considered. Upcoming systems (e.g. Graphnet, LHCRE) and 'Pushing the boundaries' and testing the norms to push the boundaries within which digital solutions currently operate. Surrey Heartlands will form the first HIMMS 7 system global digital exemplar.

Integrated Care Partnerships

ICPs are a key vehicle to drive our new models of care at a local, community neighbourhood[16] level. The next section describes each of our 'place' based ICPs' overarching development, local challenges and aspirations for the next 5 years. Specific place based service developments are shown throughout the following chapters.

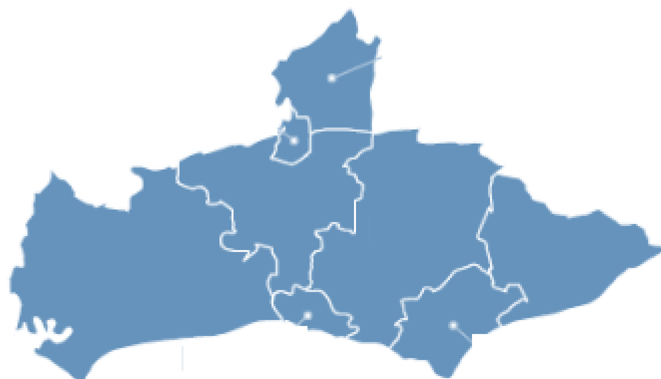
East Surrey Integrated Care Partnership

East Surrey is as an emerging Integrated Care Partnership (ICP). The ICP has embarked on a development programme which is underpinned by a recognition amongst partners that building trust and relationships will be key to the success of news ways of working in the emerging ICP. The key rationale for an ICP developed around the Surrey and Sussex Health Care system is based on patients accessing the services.

East Surrey joined Surrey Heartlands ICS recently with accountability for the CCG formally transferring on 1st November 2019. The ICP spans across Sussex STP and Surrey Heartlands ICS; with patient flows split equally between two main acute trusts Surrey and Sussex Healthcare Trust (SASH) and Brighton and Sussex University Hospital (BSUH). There are two Community providers First Community and Sussex Community Foundation Trust and two Mental health providers; Surrey and Borders Partnership Trust (SABP) and Sussex Partnership Foundation Trust (SPFT).

Key Facts

- Population 563,400
- Population expects to grow by 7% by 2029
- Prevalence of smoking is high, smoking quit rates are lower than the national average
- Over 65 population in the North System area higher than England average with large proportion who have two or more long term conditions
- Patients are staying longer in hospital whether admitted for emergency, non-elective or elective treatment



- More A&E attendances than peers, including a higher number of under 5 years

As an emerging ICP we believe there is a need to redesign our health and care system to ensure that our population is activated on self-care and prevention, receives joined up physical and mental health services from multidisciplinary care teams in community and acute services with access to high quality, digitally enabled care for services. The image in figure 23, highlights our key challenges and how they might be addressed.

[16] Neighbourhood means a collaborative approach to delivering local services and joined up support for people within a geographical boundary

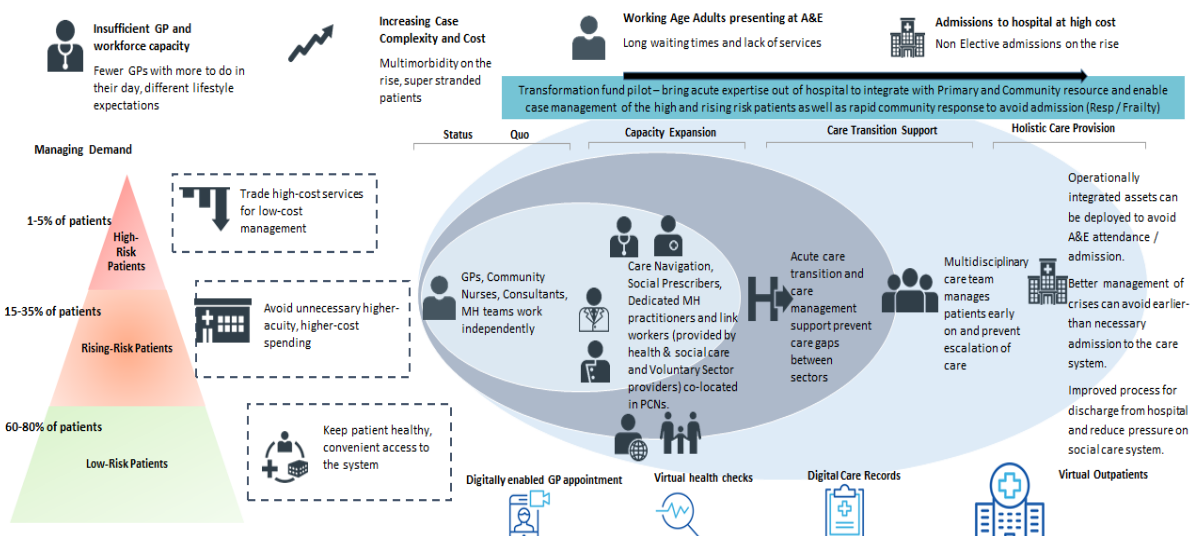


Figure 23

Our key interventions will include:

- **Prevention & PCN development**: reduce obesity & excess weight, supporting prevention and treatment of increasing risk and harmful drinking, preventing domestic abuse, promoting prevention to decrease incidence of serious conditions and diseases and helping people to live independently
- **Urgent care (including urgent community response)**: fully integrated UEC services, Home First and Extended 7 day Rehabilitation services, Discharge teams fully integrated, PCNs developing models for urgent care and frailty hubs and 2 hour Community response
- **Digital Care**: Primary Care appointments digitally available and increase in virtual consultations to reduce traditional outpatient attendances
- **Mental Health**: GP Integrated Mental Health services (GPiMs), Core 24 with therapeutic input in wards and paediatric psychiatric liaison to improve access & assessment
- **Children's services**: Children's community hub roll out within the ICP, reduction in out of area placements for children with SEND requirements and prevention
- **Estates and system assets**: Consolidation and co-location of services onto more centralised sites

Headline Financial Recovery Plan

East Surrey ICP are unable to meet the trajectory across the planning period although considerable improvement is expected, reducing the in-year position from a deficit of £32.9m in 20/21 to £21.7m deficit in 2023/24.

East Surrey ICP modelling outlines a reduction from a £30.6m deficit in 2020/21 to a £12.5m deficit in 2023/24. This does not include Horsham, Crawley and Mid Sussex CCGs as they are not in SH ICS control totals.

£m	FOT 19/20	ICP Level - East Surrey 20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	(22.1)	(30.6)	(24.9)	(18.3)	(12.5)
Surplus / (Deficit) Provider	14.0	3.4	2.7	1.8	1.9
Surplus / (Deficit) ICP level	**(8.1)**	**(27.1)**	**(22.2)**	**(16.5)**	**(10.6)**
Joint ICP level System Trajectory*	0.9	(10.4)	(9.5)	(8.7)	(8.1)
ICP Gap to system Trajectory	(9.0)	(16.7)	(12.7)	(7.8)	(2.5)
Joint System Efficiencies					
Savings in plan - Commissioner 1.0%	2.8	2.5	2.6	2.7	2.8
Savings in plan - Provider Recurrent	6.0	3.9	4.2	4.4	4.7
Savings in plan - Provider Non Recurrent	0.0	0.0	0.0	0.0	0.0
Savings in plan - Other	2.8	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**11.7**	**6.4**	**6.8**	**7.1**	**7.5**
Savings %		**1.0%**	**1.0%**	**1.0%**	**1.0%**

System Recovery: principles and context

The system has a substantial historical underlying deficit which is currently held within commissioner positions; in 2019/20 the forecast outturn for the 3 main CCGs within the ICP will be c£(100.9)m deficit. The ICP has a large population comprising of a complex system landscape spanning Sussex and Surrey, with multiple providers covering two local authority boundaries.

The key known issues within the system are as follows:

- Patchy history of joint working
- Complex patient flows
- Insufficient understanding of drivers of demand
- QVH strategic future
- Drivers of system deficit in terms of structural, operational, strategic
- Underinvestment in MH services
- Workforce shortage in acute and primary care
- The percentage of over 65s in the North System area is higher than the English average with a large proportion who have two or more long term conditions
- High percentage of stranded 7 day patients and 21 day patients
- There are longer than peer lengths of stay once admitted to non-elective beds (Orthopaedic, Urology, Vascular, Gastroenterology, and Diabetes)

System Recovery Process

Through November 2019 the existing fortnightly Financial System Recovery Board will continue with Surrey Heartlands attendance. The ICP will scope actions that will address the issues and set out a framework for action over the next 5 years. This will likely require some difficult decisions to deal with the issues identified. The outputs expected from this work are:

- A document by 30th November that is signed off by key partners that describes the basis of action going forward and which can form the basis of the strengthened Financial Recovery Board being created.
- Beginning of December the new System Recovery Board will be relaunched and jointly Chaired by Surrey Heartlands SRO and Sussex Independent Chair.

The emerging ICP Partnership Boards have been diarised each month for the remainder of the financial year. The December ICP Board will meet to agree the membership, purpose, Terms of Reference of the ICP Board and how it will conduct its business. To inject pace into the development, it is proposed that there will be fortnightly core ICP Senior leadership team meetings established to act as the Delivery subgroup of the ICP Partnership Board.

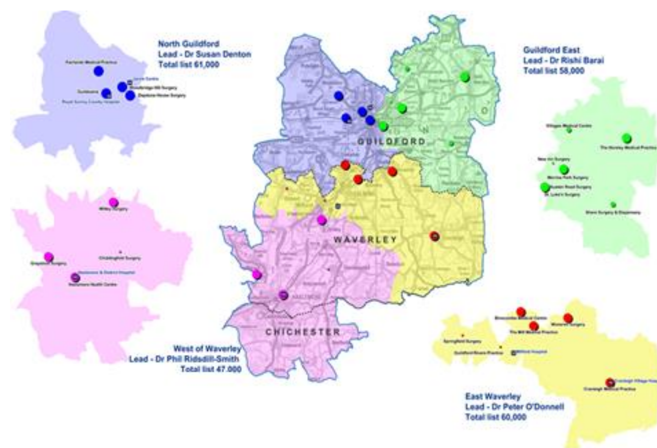
Guildford and Waverley Integrated Care Partnership

By March 2024, ***Guildford and Waverley ICP*** *will have built resilient and empowered residents and communities, through a network of stakeholders working as one team. The ICP partnership will steer and oversee the design and delivery of integrated health and care services, improving the outcomes and extending a prevention offer for the residents of Guildford and Waverley. There is a clear ambition to enable people to stay well, live well and die well, and for people to be supported in their own homes wherever possible.*

Guildford and Waverley (GW) ICP has brought together a group of local partners from GPs, commissioners, local councils, Surrey County Council public health and adult social care, the local acute and community service providers along with the ambulance service, community, voluntary and faith sectors with mental health and the children's services provider. They have been co-designing a new model of care where there is a greater focus on independence and prevention and a recognition of the impact the wider determinants of health have on citizen's health and wellbeing, and have developed a compelling vision for the system and have a set of principles that bind us together in the work to integrate our approach, and delivery of services.

Key Facts

- Population 230,000
- Affluent residents at higher risk of increased alcohol consumption leading to various cancers and liver disease
- Over 65 population is expected to rise by approximately 19% by 2027, aged 75+ projected to increase to 23,100 by 2024; 21% increase
- Guildford has significant homeless population



Our New Model of Care Programme

We have developed 6 major programmes of work. The programmes align with the national and SH ICS priorities and have leadership drawn from across our partners. Within each there are delivery teams focused on specific tangible actions.

- **Primary Care Networks:** Strengthening primary care is the foundation of delivering a sustainable community model of care to be delivered at scale with multi-disciplinary teams and new roles such as physio first, clinical pharmacists and social prescribers. Long term condition management such as Cardiology, and Diabetes will be managed in PCNs proactively. Our integrated Respiratory service will have further investment to develop further.
- **Integrated Care:** investing an additional £2m recurrently in community crisis response to avoid admission, integrating with social care reablement to support discharge. Proactive care and IV support outside hospital. End of life services are also being reviewed. We have invested in a team to support care homes to better manage frail patients in our 2,297 beds in 69 care homes.
- **Independence and Prevention:** working with the community, voluntary and faith sectors we have successfully won a charitable funded bid to rollout the Reconnections service tackling loneliness and social isolation. We are working closely with our two borough councils to build active communities building on the richness of local community assets helping citizens to take on more responsibility for the health and wellbeing.

- **Planned Care, Outpatients and Cancer:** we are redesigning pathways reviewing when diagnostics will be completed and reducing the number of face to face contacts and replacing many with one stop and virtual contact. Through the ICP we will build on our co-design approach to improve patient navigation and support after care through more Personalised Care. With a major cancer centre in Guildford we are active in prevention, developing new pathways and rapid diagnostics, excellent quick treatment and ongoing after care and support.
- **Integrated Women and Children's:** we are working closely with the Surrey wide team to deliver changes in the first 1,000 days and transforming Maternity and Children's services introducing community hubs in both.
- **Integrated Mental Health:** working with the Surrey wide team we're looking to recognise one mind and one body and the integration of care across both. We are seeing positive investment in primary care to better support those with MH needs.

Driving Integration

The Guildford and Waverley ICP will achieve its Long Term Vision via a structured and well managed Programme of work; governed by the Guilford and Waverley ICP Board. We are creating ongoing opportunities for our stakeholders to engage and help to continually shape our health and care provision. This includes clinicians and citizens in the newly created Reference Groups, will ensure that the views of all partners in change are taken into account. Our new ways of working together in partnership are:

The **integration of delivery teams** in the OOH space with community teams, hospital discharge and admission avoidance teams with adult social care teams will as they become embedded allow a "One Team" approach which will remove from of the barriers in place currently. We will invest in technology to help better manage people in their own homes and take proactive action before a more serious onset of symptoms occurs. We will build on the machine learning and AI developments in the THIM for dementia work locally working closely with the University of Surrey.

The role of the **PCNs to become the local organising entity** for community teams is key. In GW the plan is to not just align the adult community teams to primary care areas but to transfer the staff as well. This creates new opportunities to deliver seamless local care.

A **population health management focus** will enable our PCNs to focus on key health and being issues in their localities. We will invest in targeted interventions to help meet those needs better working through a more integrated operationally delivery system. We will also invest more in prevention and independence initiatives to support local people to take greater ownership of their own health and wellbeing. This will involve creative partnerships with community, voluntary and faith based groups. We will use technology to better support people.

New investments in community teams and new physical assets will enable the acute hospital to decompress from a busy and congested site. Already there have been new investments in diagnostics in the community with Digital X-ray in two community sites enabling more specialist clinics to be completed closer to where people live. Pathology services will be introduced to enhance the local offer further. Initially we will see specialist clinics supporting those with long term conditions being managed closer to home in partnership with local primary care multi-disciplinary teams.

The **role of the VSCF sectors** in GW is already significant and there is an appetite in our area to do more work with these partner organisations. We are committed to co-designing the new service models with partners and developing new ways of meeting our citizen's needs.

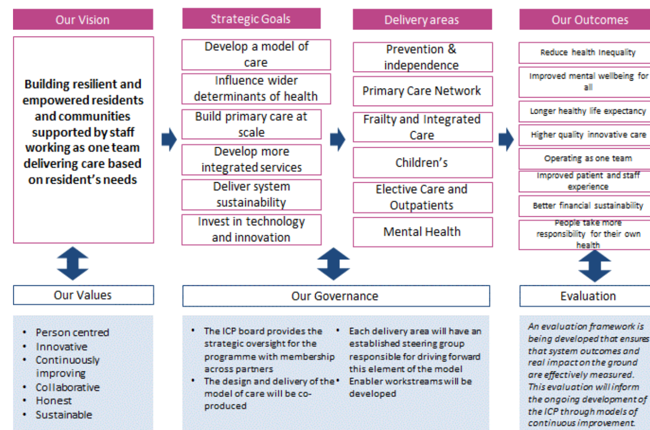


Figure 24: delivery framework to achieve our long term vision

Headline Financial Recovery Plan

£m	ICP Level - G&W 20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	(6.7)	(2.2)	0.7	2.6
Surplus / (Deficit) Provider	2.7	2.4	2.2	2.7
Surplus / (Deficit) ICP level	**(4.0)**	**0.2**	**2.9**	**5.3**
Joint ICP level System Trajectory*	0.1	1.7	3.2	4.6
ICP Gap to system Trajectory	(4.1)	(1.5)	(0.3)	0.7
Joint System Efficiencies				
Savings in plan - Commissioner 1.0%	2.8	2.9	3.0	3.1
Savings in plan - Provider Recurrent	6.0	6.2	6.4	6.5
Savings in plan - Provider Non Recurrent	6.0	6.2	6.4	6.5
Savings in plan - Other	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**14.9**	**15.3**	**15.7**	**16.1**
Savings %	**2.1%**	**2.1%**	**2.1%**	**2.1%**

Guildford & Waverley ICP modelling outlines a reduction from a £4m deficit in 2020/21 to a £5.3m surplus in 2023/24.

North West Surrey Integrated Care Partnership

Ensuring we respond to changing population need and our current challenges, by March 2024 North West Surrey ICP will have brought change to the traditional relationship between provider and commissioner. Services will be provided holistically, making the best use of resources available across our System, delivering a single set of outcomes that will be agreed across all partners.

Our ICP will bring a change to the traditional relationship between provider and commissioner; and drive the integration of health and social care.

Key Facts

- Population 368,000
- 4,500 births per year
- Most ethnically diverse of the Surrey Heartlands ICP areas
- Generally healthier population compared to England average but with variation

We have established six priority programmes of work aligned to national priorities (figure 25).

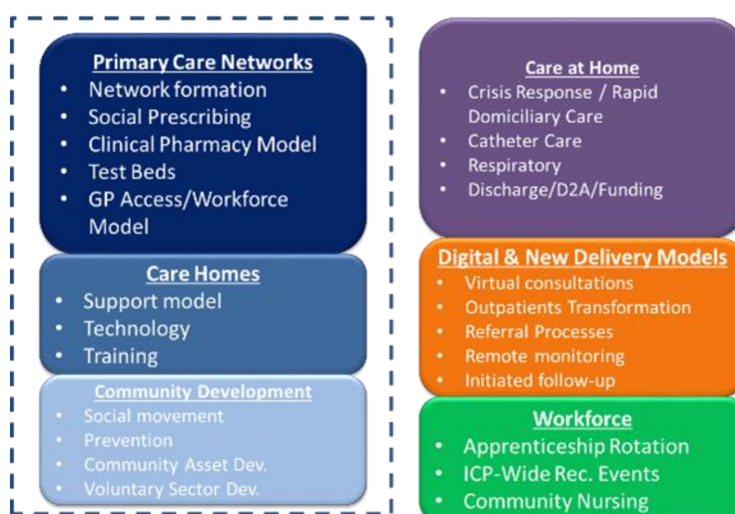


Figure 25

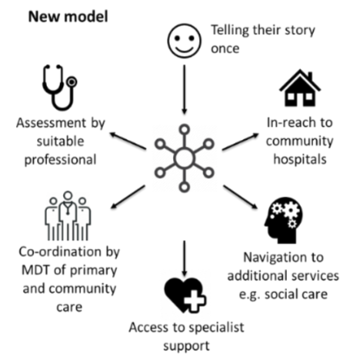
These are underpinned by single leadership across organisations and a dedicated delivery team in each area working across the System:

- **Primary Care Networks:** building multi-disciplinary teams around PCNs, expanding access to primary care and developing new primary care roles e.g. clinical pharmacists and social prescribers
- **Care Homes:** implementing the Enhanced Health in Care Home framework as Vanguard fast-followers including new technologies for monitoring, intervention and communications
- **Community Development:** building vibrant communities through harnessing local assets from grassroots organisations and the voluntary sector creating a culture and environment that supports people to live healthy lives
- **Care at Home:** significantly expanded services in the community, implementing the standards set out in the Ageing Well framework, developing mental health crisis services and establishing a single System for meeting long-term needs whether they be health or social care

- **Digital:** embracing new technologies to deliver a material proportion of service contacts through modern channels and improving efficiency
- **Workforce:** a strong focus on some of our most significant workforce challenges, developing new roles and new strategies for recruitment and career development

Driving Integration

Health and care services have developed intermittently over time and in silos across different parts of the System. The ICP represents a vital opportunity to work together to have a positive impact on improving health and care services and outcomes for our residents.



We will work to provide care around the individual; building communities not services. Focused on meeting the needs of our local residents and supporting our workforce, we have developed our Model of Care, the North West Surrey Tree (figure 26), which provides a common ideal across the ICP and a beacon for what we are working towards in all of our endeavours to improve local services over the next 5 years. The model presents a vision of an empowered, activated and resilient community, supported by integrated teams organised around primary care networks; working collaboratively with Secondary and tertiary care.

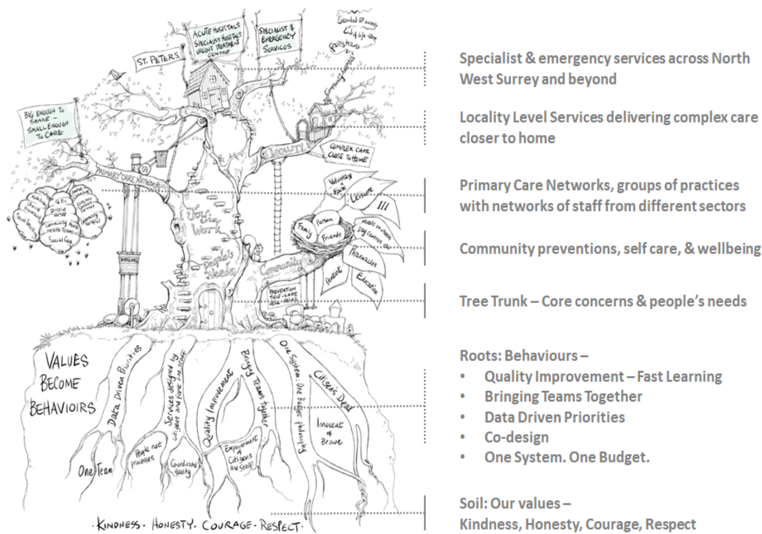


Figure 26

Where statutory services are needed, these will be set up to work as efficiently and effectively as possible with a much greater focus on community and out of hospital care (figure 27).

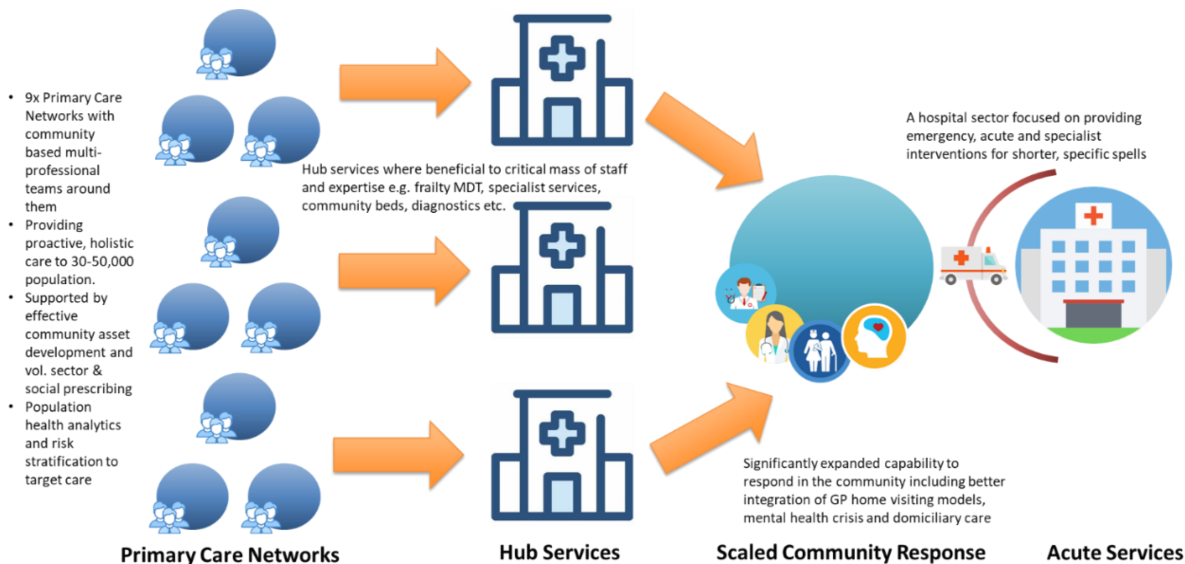
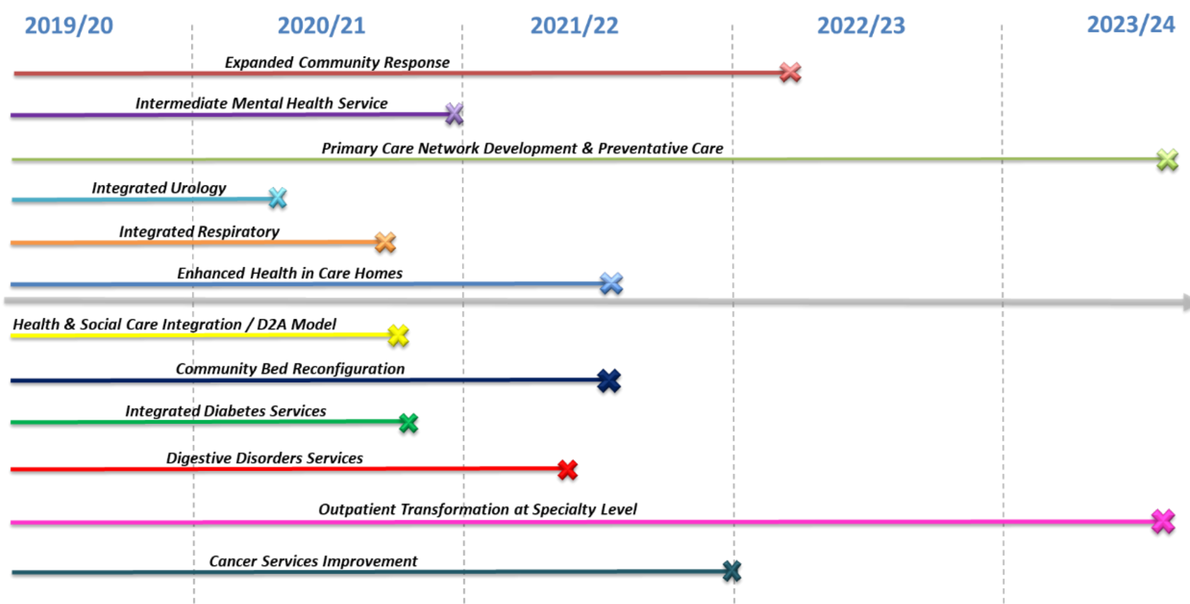


Figure 27

Our indicative 5 year delivery plan



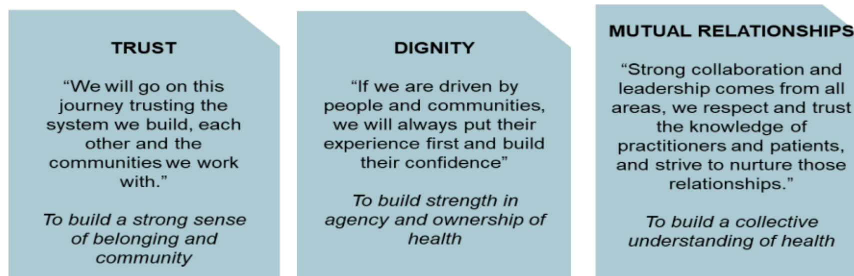
Headline Financial Recovery Plan

	ICP Level - NWS			
£m	20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	0.1	0.4	2.8	6.2
Surplus / (Deficit) Provider	1.6	1.3	1.9	1.8
Surplus / (Deficit) ICP level	**1.7**	**1.7**	**4.7**	**7.9**
Joint ICP level System Trajectory*	1.6	1.6	1.7	1.7
ICP Gap to system Trajectory	0.1	0.1	3.0	6.2
Joint System Efficiencies				
Savings in plan - Commissioner 1.0%	4.9	5.0	5.2	5.4
Savings in plan - Provider Recurrent	5.3	3.8	5.7	5.9
Savings in plan - Provider Non Recurrent	0.0	0.0	0.0	0.0
Savings in plan - Other	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**10.1**	**8.8**	**10.9**	**11.3**
Savings %	**1.1%**	**1.0%**	**1.2%**	**1.2%**

North West Surrey ICP modelling outlines an improvement from a £1.7m surplus in 2020/21 to a £7.9m surplus in 2023/24.

Surrey Downs Integrated Care Partnership

By March 2024 ***Surrey Downs ICP*** *will have created a fully integrated Health and Care System that is built around the people and communities of Dorking, Epsom and East Elmbridge, and is continually evolving through System wide collaboration and co-creation. In doing so we collectively aspire to be an exemplar of how to deliver highest quality and best value care in a complex health and care System. We aim to move towards a System that provides integrated care led by the individual with wrap around services, moving from a dependency on navigating individual organisations to a one System focussed on meeting all needs of the individual and local communities achieving improved outcomes for all through a core set of principles;*



We will realise our vision through partnership working and a core set of values:

Key Facts

- Population of around 306,000
- In Surrey Downs it is predicted that the over 65 population will have increased by 21% in 2027
- Evidence has suggested that here is a significant proportion of the population in Surrey Downs that have undiagnosed Long Term Conditions
- There are examples of inequality between the Surrey Downs affluent areas and more deprived areas, especially around access to treatment, diagnostics and health outcomes
- The review of care plans for Mental Health, especially Dementia is an area that Surrey Downs can improve on

Surrey Downs overall is an affluent area, with good health outcomes and relatively low rates of many conditions and unhealthy behaviours; however, this masks some inequalities within the area, with some groups/smaller areas having significantly greater needs or worse outcomes. The data highlights

key areas for consideration, including health inequalities, the growing population of those aged over 65, access to services for those without a car, a higher incidence of breast cancer, and significant proportions of people estimated to have long term conditions being undiagnosed.

The partners of Surrey Downs Integrated Health and Care Partnership have made significant progress towards the creation of a fully integrated System being co-created with all partners, lay members and local residents.

Our priorities have included a focus on **delivery of care as close to home as possible** ensuring that **care is wrapped around the needs of the individual**. As a System we are keen to continue our move to a **proactive approach**, empowering our teams to continually innovate and encourage residents to have more input into their **health and wellbeing journey**.

Our Journey started through the development and launch of Surrey Downs Health and Care; **promoting an integrated approach to health and social care**. This initial transformation programme sparked an increased momentum for collaborative working with a wider partnership that then went on to become our Integrated Care Partnership Board for Surrey Downs.

How will we work together as partners for the people of Surrey Downs

As a System we have made significant progress towards the transition to a Committee in Common approach, developing a structure that will enable us to work collectively to implement change and make key decisions about the provision of health and care for our local population. Once we have achieved this, we will be able to; Implement the Partners' shared vision and more importantly take stewardship of the health and care System in Surrey Downs to implement the Partners' shared objectives.

A key part of this integration progression is a focus on how we manage the market, working together as partners to understand how we can manage activity effectively in order to achieve maximum efficiency for our System and local residents; in particular we are looking at how we transform out of hospital services so we can reduce attendances in A&E allowing them to focus on the most acutely ill patients.

A number of significant milestones in this transition have already been achieved; including the establishment of Surrey Downs Health & Care (an innovative new partnership for the delivery of community care), creation, in line with the NHS Long Term Plan, of the six Surrey Downs PCNs, establishment of the Surrey Downs ICP board and associated transformation plan, and the joint development of a System Finance Recovery Plan (FRP).

At the same time, we are working with partners across the border in South West London as an active partner in the Improving Healthcare Together programme (along with Sutton and Merton CCGs). This is a major change programme aimed at making sure people are able to access high standards of healthcare locally and that these are sustainable into the future. The success of this programme is a key element in providing the solution to long-standing financial issues in this geography. Focused around Epsom & St Helier University Hospitals NHS Trust, the programme aims to address a series of long-standing healthcare challenges around clinical standards and staffing.

How will we deliver our transformation programme

The Surrey Downs ICP model of change will use PCN footprints as test beds for prototyping, with staff from across the System working together to design and deploy innovative projects and solutions. We currently have integration projects up and running in all six PCN footprints including Integrated Mental Health and a pro-active integrated approach to childhood asthma.

Our Transformation Programme set to be delivered over the next 2 to 5 years, is continually evolving around the needs of our local population and system. It has 5 key priority areas shown in figure 28 and is well aligned with a number of aspirations and commitments as set out by the long term plan,

the Surrey Heartlands Health and Wellbeing Strategy and intelligence relating to the needs of our local populations.

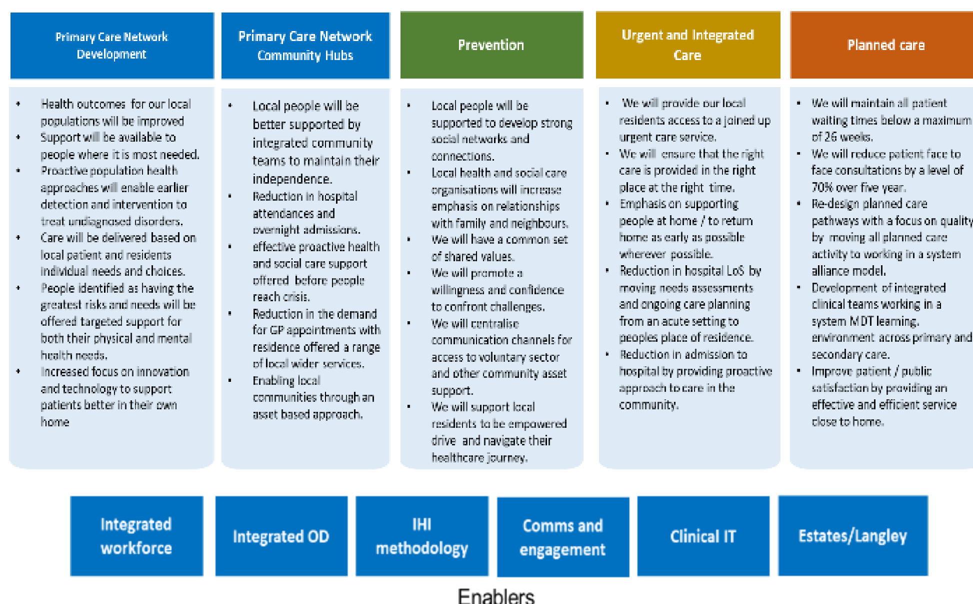


Figure 28

How will we know we are doing the right things

- **Staff:** Improved Staff morale and energy, a feeling of one team one goal
- **System:** Shared response to addressing challenges and co-creation of solutions
- **Outcomes:** Better System performance and better outcomes for patients and local residents
- **People:** Patients and local residents will talk about care provided to them by a team not by individuals or organisations
- **Finance**: Financial Recovery Plan and improvements to System productivity and efficiency outside of the plan 'should be one of the bi-products of the new way of working

Headline Financial Recovery Plan

Surrey Downs ICP has a challenging trajectory and although this is not delivered within the planning period, there is a significant reduction in the year on year deficit moving from £14.9m deficit in 2020/21 to a position of breakeven in 2023/24. This represents a significant improvement in the underlying year on year position. This is Surrey Downs CCG only as Epsom & St Helier Trust is not within the Surrey Heartlands ICS Control Total position.

	Commissioner Plans - SD			
£m	20/21	21/22	22/23	23/24
Commissioner Allocation	451.3	463.3	482.1	498.2
Commissioner Expenditure	(466.2)	(473.2)	(485.7)	(498.1)
Surplus / (Deficit) (excluding incentives)	**(14.9)**	**(9.8)**	**(3.7)**	**0.1**
System Trajectory*	2.4	4.2	4.4	**4.5**
Gap to system Trajectory	(17.3)	(14.0)	(8.1)	(4.4)

The modelling outlines a reduction from £14.9m deficit in 2020/21 to a £0.1m surplus in 2023/24.

Surrey Wide Services Integrated Care Partnership

Developing our integrated, at scale services through our Surrey Wide Integrated Care Partnership.

We have started to develop Surrey Wide Integrated Care Partnerships focused on areas including Children's and family's services, Learning Disability and Autism, Mental Health and Continuing Health Care. This will enable us to continue to develop our integration model with Surrey County Council. We already have a number of joint posts with the Council and over the next five years we will use both the flexibilities of devolution and the use of section 75 agreements to create a fully integrated leadership model. This is supported by a broad ambition to achieve operational integration at a place and community level. We collectively believe that a transformative approach is the only way to deliver our ambitions.

We want to ensure that every pound spent is targeted and delivers value for money and fundamentally believe that we can improve outcomes for residents and communities whilst reducing demand and long term dependency, thus saving state expenditure.

In line with our Community Vision 2030, **we want to drive a profound and whole scale shift towards prevention** and supporting individuals and communities to better support themselves, thus enabling individual and communities to thrive. To support this, we are **committed to reducing demands on and the cost of acute services in Surrey and to jointly investing in preventative** activities and services. You can read about these delivery plans for these services in chapter 6.

Chapter 5: Prevention & Health Inequalities

By March 2024, in support of the Surrey Health and Wellbeing Strategy, we want our citizens to feel empowered to lead healthier lives. This includes individual lifestyle factors and ***preventative*** *changes.*

Our Communities across Surrey will be stronger. Residents will be contributing to co-designing and co-producing local health and care services and will be increasingly taking part in their communities and helping make their local neighbourhoods great places to live, work and learn. Community strengths will be increasingly known and used to the full and residents will be supported to access them through social prescription. Families and individuals will be supporting each other and fewer people will report feeling on their own.

It is important to Surrey Heartlands to embrace what our communities have to offer and assist them in promoting and developing what they can offer their populations to feel empowered to lead healthier and fulfilled lives.

Communities

Evidence tells us that *'…the well-connected are more likely to be hired, healthy, happy and housed*[17]*'*. And national policy acknowledges that *"strong local communities are fundamental to our nation's wellbeing and prosperity*[18]*."*

However it is described, **volunteering**, **social action** or simply **people helping people**, the health and wellbeing outcomes of people can be transformed by using the skills and talents of the local community. Evidence suggests social action can **change lives** through the benefits of empowerment, self-efficacy and increased social connections.

In Surrey, we recognise that communities, and the social networks within them, have a huge impact on the wider determinants of health and the overall health and wellbeing of residents. We aim to build community development capability within the health and social care System, localised with PCNs and co-designed with citizens to gain input to delivery plans over the life of this delivery plan and beyond.

We are committed to building clear channels through which we can engage with local communities. Citizens require communication channels that are easy to access and use, with clear, unified messages. To work collaboratively alongside communities, we are considering how statutory organisations in Surrey operate, so that we empower, build capacity and resilience, and increase independence.

This will require a range of innovative approaches based on co-design and co-production with residents, where we increasingly recognise community support as a valuable asset in creating and sustaining good health.

We want to make this happen by working with ICPs and PCNs by:

- Expanding social prescription services that help point people to community based support
- Reviewing our approach to support provision so that we make best use of community assets, using an asset based community development approach to respond to needs identified through social prescription in order to provide relevant opportunities in the community

[17] *The Place of Social Capital in Understanding Social and Economic Outcomes*, Michael Woolcock, ISUMA Canadian Journal of Policy Research (2001)
[18] Ministry for Housing, Communities and Local Government – Community Framework (July 2019)

- Co-designing with the community sector how we could help increase its capacity and sustainability, and establishing support mechanisms for communities to equip and empower them to take their ideas forward
- Embedding a population health management approach within the social prescription service and any community development initiatives
- Exploring behavioural insights into community participation, co-designing the language to describe strong communities and community participation and communicating effectively
- Supporting development of infrastructure that allows residents to take part in their communities, especially for those cohorts who may have previously experienced exclusion from community life
- Working alongside a small number of communities to understand and then model how community-statutory partner collaborations could be most effective.
- Maximising corporate social value for the benefit of local communities.

We expect residents to see over the next 5 years:

- Increasing numbers of residents accessing community support and benefiting from this
- Targeted approaches to support those who would most benefit from community participation
- Community support opportunities developing in diversity, capacity and resilience
- Increasing awareness of ways to could contribute to community life amongst everyone who lives, works, learns or travels in Surrey.
- Increasing opportunity for residents to contribute to co-designing and co-producing the services in their local area

Social Prescribing

Social Prescribing is a key enabler to support the System and our citizens move to a preventative approach to health and care management. Social prescribing is a way of enabling primary health and care professional to refer people to a range of local, non-clinical services. We plan to extend the variety of professionals able to refer to the services such as through pharmacy, as well as the range of services. By recognising people's health is determined primarily by a range of social, economic and environmental factors, we are seeking to address people's needs in a holistic way and support them to take greater control of their own health.

We plan to:

- Have Primary Care and Local Authority work in partnership to provide social prescription services
- Identify cohorts who would most benefit from social prescribing and proactively offer them a social prescription.
- Integrate social prescription with a population health management approach to support those who would most benefit from the support
- Support people to access help outside of primary care where appropriate by offering social prescription from other referral points, such as pharmacy
- Support the community sector to provide relevant support options for local people and to increase capacity and resilience.

Social prescribing schemes can involve a variety of activities such as volunteering, befriending, healthy eating advice and a range of sports. **39 trained social prescribing link workers will be in place by the**

end of 2020/21 rising further to 83 trained workers by 2023/24, with the aim that over 17,000 people are able to be referred to social prescribing schemes.

The increase in workers will be through recruitment in line with the GP contract reform funding and local delivery models are in collaboration with PCNs and existing social prescription providers; most commonly a VCFS organisations or borough council.

Monitoring and evaluation are in place to evidence impact and recommend further staffing and activity over the remaining 4 years of the funding. For example – monitoring time per client by support need to model capacity of each link worker and expected outcomes for target cohorts from 2020 onwards. Modelling this using patient coding from PCNs and national best practice impact data will enable us to:

- identify some target cohorts most likely to experience benefit from social prescription and reduce their inappropriate health service usage.
- propose expected outcomes from social prescription intervention.

We expected citizens to see over the next 5 years:

- Increased support to address the wider determinants of health
- Reduced primary care usage for non-medical needs
- Increased access of community-based support

People have a healthy weight and are active

We aim to create an environment and community which enables physical activity and healthy eating across the life course for all. **We plan to reduce the rate of obesity attributable hospital admissions in our population from our current rate of 664 per 100,000 to 656**. We plan to increase citizen's use of outdoor space for exercise and health reasons from our **current rate of 20.5% to the 'best in class' rate of 24.4%**. We want to create health behaviour support for vulnerable groups and those with the greatest need to optimise their opportunities to lead healthier lives. And for those with a learning disability and/or autism to have access to facilities with healthy eating options.

We want to:

- Develop whole Systems approach to physical activity including improving use of green spaces, transport initiatives, and healthy planning
- Integrate and align Health behaviour (including sleep) strategies and services across the Life Course
- Implement 'Healthy High Streets' approach with a focus on the most deprived areas and residential care
- Develop a heath behaviour offer for deprived and vulnerable groups (including routine and manual workers, pregnant women, carers and those with a learning disability and/or autism)

We expect citizens to see over the next 5 years:

- Implementation of National Child Weight Management Programme
- Reduction in rates of Obesity
- Decrease in the percentage of physically inactive adults
- Increase in the percentage of people accessing green spaces
- Reduced obesity in adults with Learning Difficulties reported at a health check

Smoking

We aim to continue to develop the opportunities for a smoke free Surrey by reducing uptake and supporting those who need the support to stop. Our current smoking rates among adults employed in routine and manual occupations is **21.5%**. This group have significantly higher prevalence than the general population and fall within the 20% most deprived super output areas (and associated PCNs). We aim to reach the 'best in class' rate of **11% for this population**.

We will:

- Develop a joint Alcohol and Tobacco Alliance for targeted support to address inequalities such as smoking status recorded for all maternity, smoking at time of delivery data, sign up to the NHS Smokefree pledge
- Refresh the Tobacco control strategy and supporting action plans to further progress JSNA recommendations such as smoking status recorded for all maternity, smoking at time of delivery data, sign up to the NHS Smoke free pledge
- Implement targeted approaches for vulnerable groups to stop smoking through the local specialist service commissioned by the local authority
- Embed brief identification and brief advice for smoking and alcohol into patient pathways
- Promote '28 day challenge' for residents to stop smoking with the support of the specialist service commissioned by the local authority

We expect citizens to see over the next 5 years:

- Reduction in smoking rates in people working in routine and manual professions

Substance misuse (drugs/alcohol) is low

We want to ensure safe and social alcohol use throughout Surrey Heartlands. Alcohol statistics published by the Health and Social Care Information Centre[19] in 2016 indicate that while admissions rates in Surrey remain significantly lower than England, the narrow measure is showing a year-on-year increase in alcohol-related admission episodes locally, with an 11% increase between 2008-09 and 2014-15. It is generally understood that **21% of adults** in Surrey who drink, do so at increasing risk levels and **6% at higher risk levels**[20].

Where people require support there will be a coordinated approach to identification and support for high risk areas and communities, where people are supported to identify and address alcohol risk.

We want to make this happen by:

- Refreshing the Substance Misuse Strategy with a wider consultation including alcohol develop an Alcohol & Tobacco Alliance to increase focus on alcohol prevention and improve universal approaches to reducing increasing and higher risk drinking partners
- Refreshing the Substance Misuse Partnership to have a greater focus on alcohol
- Integrating and aligning health behaviour strategies and services across a lifetime
- Embedding 'identification' and 'Brief Advice' in clinical pathways across primary and secondary care including, e.g. ED, IAPT and Social Prescribing and Alcohol Action Teams in ED's

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[19] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2016
[20] https://www.surreyi.gov.uk/jsna/improving-health-behaviours/#header-alcohol-related-hospital-admissions

- Health Checks targeted to Carers, those with SMIs and people with Learning Difficulties
- Develop a programme to address access to substance misuse and mental health services for those with severe and multiple disadvantage

We expect citizens to see over the next 5 years:

- Reduced Excessive Alcohol Consumption Rates
- Increased successful alcohol treatment completion rates
- Reduced number of young people (aged 0-17) in specialist substance misuse services
- People are supported to identify and address alcohol risk
- A coordinated approach to identification and support for high risk areas and communities

People are supported to live independently for as long as possible

We want to ensure that people are supported to manage Long Term Conditions, people receive joined-up, person-centred services and only need to tell their story once, people are supported to die in a place of their choice and that people live independently at home for as long as possible.

We plan to:

- Use the Better Care Fund to engage with wider partners and develop System-wide services
- Develop integrated, countywide response for people living with Dementia
- Support the development of a Technology Enabled Care service
- Develop a robust, integrated, preventative Intermediate Care offer
- Agree a System-wide communication and financial strategy for End of Life Care

We expect citizens to see over the next 5 years:

- The increase in the rates of deaths in usual place of residence in those aged 65+
- More people able to live independently for longer

Improving the next generation's health

*By March 2024, in support of the Surrey Health and Wellbeing Strategy, we want our citizens to feel empowered to lead healthier lives. This includes individual **lifestyle factors**, but also considers built environments and how that impacts on health.*

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. We are making an important shift to a more preventative approach, addressing root causes of poor health and wellbeing including things like poor housing and the environment and not simply focusing on treating the symptoms (wider determinants of health).

Our ambitions for our place include:

- Residents live in clean, safe and green communities, where people and organisations embrace their environmental responsibilities.
- Well-connected communities, with effective infrastructure, that grow sustainably.

Improving environmental factors
We want people who live and work in Surrey have an increased awareness of the health impact of poor air quality and take action to improve air quality. In July 2019, Surrey County Council declared a climate change emergency. As a result we will be increasing the number of ways we input and influence decisions on our environment; citizens will see engagement in the 'Development Consent Order' process for airport expansion applications, the implementation of the 'Surrey Transport Plan for Low Emissions Transport Strategy', 'Deliver a Schools Air Quality Programme' and Surrey-wide communications campaigns to raise awareness of the importance of good air quality and environmental sustainability, in our commitment to achieving net zero carbon emissions by 2050.

Surrey County Council will continue its work in Public sector organisations, embedding environmental sustainability. We will shortly publish guidance for health systems and local planning in Surrey. Organisations across Surrey will be supported to have Sustainable Development Management Plans in accordance with regulatory requirements, approved by their board.

Healthy Environments
Our work continually aims to provide environments which support the health of our communities. Supporting our 10 year plan we will:

- Promote healthy, inclusive and safe places through planning policies/decisions and transport/highways policy, projects and operations
- Maximise opportunities for health to influence Local Plans and draw no available funds, such as the Community Infrastructure Levy
- Ensure people who live and work in Surrey have an awareness of the health impacts of poor air quality and environmental sustainability and take action to support these
- Reduce death and injury on Surrey roads
- Increase active travel across Surrey
- Ensure local residents and strategic partners understand the importance of seasonal health and wellbeing and undertake interventions to reduce the health impact of hot/cold weather
- Continue to monitor and review environmental impacts on health and local priorities

We expect citizens to see over the next 5 years:
- An increase in walking, cycling and access to green spaces

Everyone lives in adequate housing
We want people who live in Surrey to live in adequate housing with access to services and be able to live independently at home for as long as possible. **We want to cut the rate of 'winter excess deaths' by 50% from the current rate of 21.3**[21]. For those that require support, they will have easy access to the services they need. For people with a learning disability and/or autism they can live in adequate housing with adequate support; we want **improve from our current position of 66% of this population to 87% living in settled accommodation.**

To make this happen we will:
- Develop a jointly commissioned pathway for single, homeless people with complex needs (Making Every Adult Matter(MEAM))
- Develop a fuel poverty offer for those living in crisis

[21] Under review by Surrey Health and Wellbeing Board

- Fully implement the Surrey aids and adaptations review to ensure there is a consistent adaptations service available across Surrey
- Develop specialist housing, integrated into care pathways and aligned to the reablement programme
- Map of existing homeless initiatives, housing data and gaps
- Development of a South East regional offer to enable Surrey to deliver on its duty to provide secure accommodation and support to victims of domestic abuse

We expect citizens to see over the next 5 years:

- Increased number of older people at home 91 days after discharge
- Reduced emergency admissions rates of those with dementia
- Reduced excess winter deaths
- Number of supported adults whose accommodation status is severely unsatisfactory is reduced
- Increased number of people with a learning disability living in settled accommodation)
- Reduced homelessness rates and number of people experiencing severe and multiple disadvantage

Carers

By March 2024, our vision is that no carer should care alone or experience loneliness or isolation as a result of their caring role. Carers are respected, recognised, valued and supported, both in their caring role and as an individual.

The vast majority of care in the Surrey is provided by family and friends, who receive no payment for their caring role. Social services and the NHS rely on carers' willingness and ability to provide care without which our System would collapse. Recognising that Carers are at the heart of everything we do, Surrey should be a place where carers are respected, recognised, valued and supported, both in their caring role and as an individual.

We aim for Carers in Surrey to be able to expect to:

- Be identified as a carer as early as possible, be informed, respected and included by health and social care professionals so that **by 2020 100% of our general practices will have 2% of carer population identified**[22] and **annually increasing the number of carer prescriptions by 8% by 2024 to 4,813**
- Have choice and control about their caring role
- Be able to stay healthy and well themselves, by **increasing health checks 11% annually to achieve 3,050 by 2024 and increasing the number of flu vaccinations given to carers to 13,000 by 2024**[23]
- Have their own needs and wishes as an individual recognised and supported

[22] National measure
[23] Dependant on annual funding

- Have support in accessing education and employment, leisure and social activities or help to remain in work by **annually doubling the number of carers reporting quality of life (Zarit Burden Scale) to 1,600 by 2024**
- Have support in accessing education and employment or help to remain in work
- Have their religious and cultural needs respected
- Young carers and young adult carers should be able to thrive and develop educationally, personally and socially, and be protected from excessive or inappropriate caring roles

We aim that this support is available equally to all carers including seldom heard carers and carers who care on the margins.

Surrey Mission for Carers
We will deliver our vision through a joint Adult Carer Commissioning and Development Strategy and a Young Carers and Young Adult Carers Strategy. We will jointly commission a range of services to support carers throughout their caring journey. These services will focus on early intervention and prevention. Through our 'Surrey Carers Memorandum of Understanding' we follow an integrated approach to supporting carers across our System. This includes facilitating a Surrey Carers and Providers Network. This network will be member led with the purpose of sharing best practice including the promotion of initiatives such as the 'Carers Passport' and 'Johns Campaign'[24]. We will continue to build on our Carer Friendly Communities model and practice; putting carers at the heart of everything we do. In support of the national health care requirements, we will focus on the following:

- Primary Care -GP Carer Registration, GP Carer Quality Markers to spread best practice, GP Top Tips for Young Carers, Personalisation through GP Carers Breaks
- Develop ways where electronic health records can help share carers status wherever they present
- Promotes a whole family, whole System approach to supporting carers using shared mechanisms including a Carers Care Pathway, Young Carers Pathway, Our "Surrey Carers Prescription Service" and social prescribing
- Improve support to young adult carers; building on the 'top tips for young carers' co-design, support material available in general practice and Young Carers Champion working to support improved GP Young Carer registration
- Develop upstream prevention support for carers
- Co-design and co-produce new approaches to carer contingency planning to include staff carer contingency planning. The next co-design event in January 2020 will focus on contingency plans for out of hours care, followed by staff and carer contingency plans as part of 'carer friendly employers'
- Improve the experience of End of Life Care for Carers
- Support staff carers
- Develop our Carers Digital Offer and expand our digital access to NHS Services such as the NHS app and GP video consultation services.

There is continuing work by Surrey County Council to bring mental health adult social care staff back into locality teams to improve access for carers of people with mental health (vulnerable communities) to receive assessment and support. The development of the integrated primary secondary mental health service model has identified improving support and outcomes for carers with mental health

[24] https://johnscampaign.org.uk/#/

issues themselves or caring for people with mental health issues. We have procured online support for carers with certain mental health issues and we are continuing our ongoing work with the Ministry of Defence Pirbright to ensure joined up support for armed forces carers and training for GP veteran awareness during early 2020.

We continue to undertake significant work to improve the lives of staff carers. During 2019, a survey was co-designed with System Providers and launched during Carers Week. The results have been published and actions are being taken forward as part of the developing delivery plan, in combination of our second wave launch which will co-inside with Carers Rights Day in November 2019.

We expect citizens to see over the next 5 years:

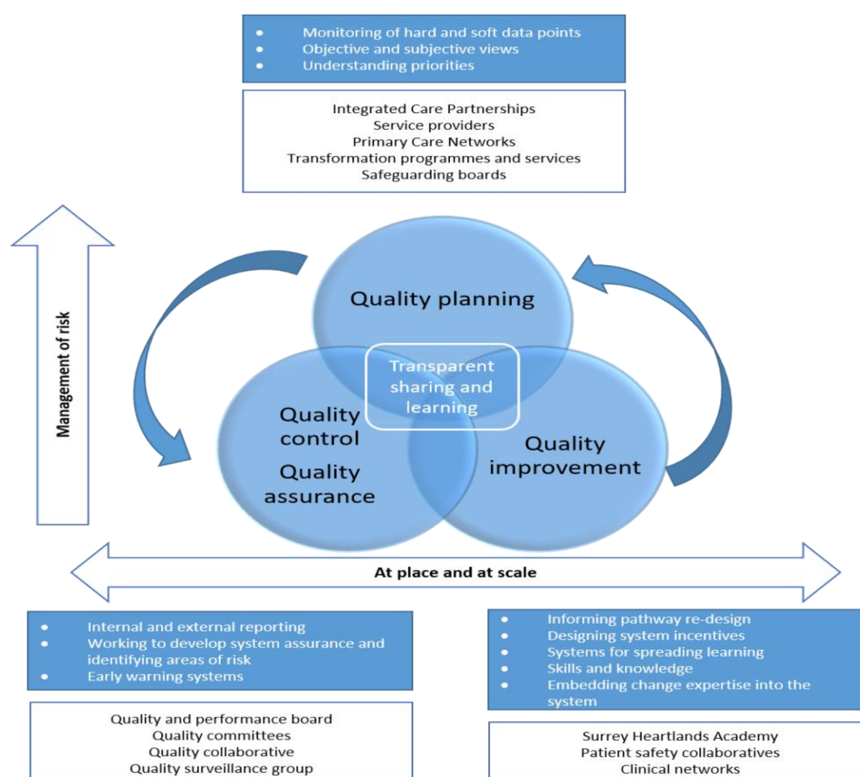
- Health Checks targeted to Carers, those with SMIs and people with Learning Difficulties
- Improvements in carer-reported quality of life
- Citizen engagement to scope out carers partnership project to help people live independently and die well

Chapter 6: Progressing Care Quality & Outcomes

Quality Leading Change, Adding Value

Surrey Heartlands have adopted a quality management System approach to help effectively manage quality. It brings together the four key principles of assurance, control, planning and improvement and allows organisations and partnerships to gain confidence in knowing they have a robust virtuous cycle of managing and improving quality.

Quality Management System



System partners are working increasingly collaboratively to support and develop both internal assurance governance processes but also to bring collective ambitions and resources together to jointly identify priorities to maintain a continuous focus on improving health and social care services for our population. We are also actively working with CQC on the development of a more targeted, responsive and collaborative approach to regulation, so more people get high quality care.

All of the Surrey Heartlands NHS provider trusts are rated 'good' or outstanding overall. 85% of adult social care services are rated 'good' or 'outstanding and 100% of GP Practices are rated 'good' or 'outstanding'. Our ambition is to continually improve our ratings across the System.

We also aim to improve the quality of care for all care homes within Surrey Heartlands as part of the Enhanced Care Home Programme: we have a vision of an empowered, activated and resilient community, supported by integrated teams organised around primary care networks; working collaboratively with Secondary and tertiary care. Primary Care Networks (PCN) supported by community hubs (have an established link to all care homes so that, in general, one GP is linked to

each home and their residents; community teams linked to PCNs provide targeted support to homes and their residents delivering, for example, timely medicines reviews, minimising the burden of medication for people so reducing adverse reactions and improving wellbeing.

Mental and physical health provision to care homes is fully integrated through these teams with talking therapies delivered into care homes directly; social prescribing and other community engagement work from our District and Borough teams are helping to embed homes more securely into their local communities. Intergenerational engagement is provided by links to local schools and other educational establishments; the internal Systems and processes of care homes now link seamlessly into the rest of the System as pathways have been developed in partnership. Care Homes are involved at the outset in service redesign, for example the integrated falls pathways. Now that care homes are routinely involved in all planning of services, this has led to an effective Trusted Assessor approach which has reduced lengths of stay in our hospitals; quality improvement, training and learning in care homes has been supported by the development of care home learning networks centred on PCNs and linked to hospices and academic institutions.

The health and wellbeing of Children and Young People (CYP) is a key area of focus across both Surrey Heartlands ICS and the wider Surrey footprint and this is reflected in the development and delivery of Surrey's programme "First 1000 days" which aims to provide the best possible start in life for the young people of Surrey. It is widely acknowledged that there have been a number of quality concerns raised in relation to delivery of children's services with continuing issues around long waiting times for assessment and referral to treatment in services such as CAMHS and Children's therapies.

The delivery of services through existing partnership arrangements is, however beginning to have a positive impact on the experience and outcomes of Children and Young People and their families as relationships within the partnership mature and solutions are focussed on meeting their needs and supporting positive outcomes. One example of this follows the recent re- visit from OFSTED and the CQC in March 2019, where it was clear that progress had been across the Surrey Special Educational Needs and Disability (SEND) services and that these improvements had resulted from closer working between Surrey County Council and its health partners. This continued collaboration has resulted in the development of an updated action plan to address the remaining areas of improvement that were identified. In addition, following engagement with Children and Young People with SEND and their families, a new Surrey Special Educational Needs and Disability Partnership Strategy has been published which gives further opportunities to support our children and young people in achieving their goals and living rewarding lives.

This example of collaborative working is being replicated in service developments across Surrey as partners see the benefits of a shared and more streamlined approach for Children, Young People and their Families.

There continues to be real concerns about quality & safety following recent examples of major failings within public services. Our healthcare providers are rated "good" or "outstanding" by the CQC. However, in our strive for improvement, Surrey Heartlands is prioritising areas to develop care for our population.

We are developing a shared vision and understanding of quality for the System, maximizing the fit into wider System architecture at ICS and ICP level and enabling delivery of our System ambitions. Our Academy is a key delivery partner for both quality improvement in this cycle and System wide transformation enablers such as workforce engagement, knowledge management, commercial development, innovation and research. This directly supports the development of the strategic quality approach, a culture of continuous improvement and the development of an integrated approach to service transformation.

Bringing together 4 key principles into a management System approach provides a framework to help effectively manage quality, allowing organisations and partnerships to gain confidence in knowing they have a robust virtuous cycle of managing and improving quality.

Through co-design and co-production with System partners, Surrey Heartlands is developing a three year quality strategy (via the management System) to support the safe transition of the quality agenda into a new System architecture:

- Year one: implementation, monitoring, embedding, test of effectiveness for demonstrable outcomes
- Year two: review of strategic direction
- Year three: The quality System approach

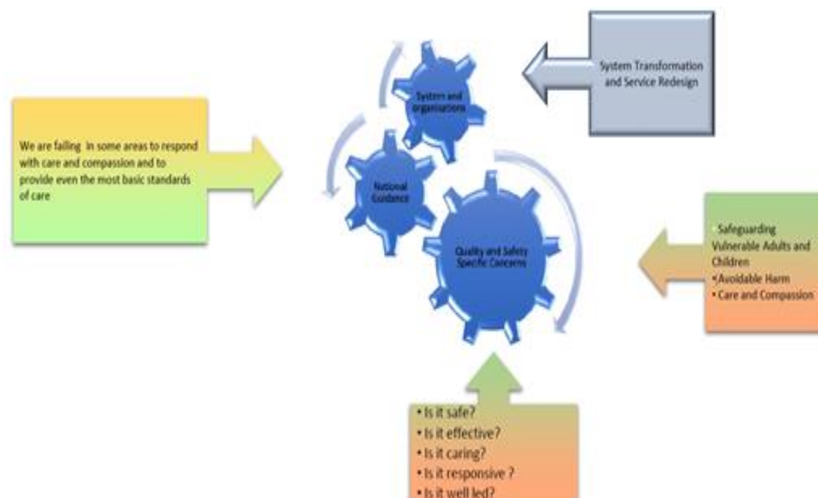
Four quarterly workshops are scheduled to focus on each of the four principles and build shared understanding and ownership.

	ICS	Quality
Vision	To work together with the people of Surrey Heartlands to improve health and care services	Shared vision and understanding of quality for the system
Why?	We want Surrey Heartlands to be a prosperous and healthy place with a high quality health and care system that is sustainable for the long term	To maximise quality fit into the wider system architecture at ICS and ICP level; scale v place; system ambitions Safe transition of quality into the new system architecture Internal/ self assurance and regulation; external regulatory system: NHSE/I; CQC; Ofsted: single reporting framework
What?	Surrey Heartlands Plan (PWC reviewing priorities against NHS 10 Year Plan)	Quality Strategy for the ICS: aim; purpose (shared principles); outcomes (deliverables; measureable – 5 top priorities)
How?	We plan to do this by: Supporting and enabling people in Surrey Heartlands to be healthier Providing high quality and accessible care for those who need it Creating partnerships that work better for the people we serve and those who provide care Working closely with our Academy to develop and embed a QMS and Sysetm wide Quality Improvement approach	Through development of a robust governance framework (ICS and ICP assurance); Quality Management System; aligned governance across systems and pathways through a shared assurance framework Through aligning enabling workstream priorities and reducing overlap to maximise potential e.g. workforce; digital; Academy objectives Leadership; engagement and cultural and behavioural change: co-design and collaboration Effective change management
Who?	These are alliances of local health and care organisations, including CCGs, GP federations, our borough colleagues, the voluntary sector and others.	Stakeholders and citizens across Surrey Heartlands at both place and scale
When?	By 2020	First 3 years; safe transition from CCG into ICS governance framework; transformation that is effective and efficient; integration and devolution and recognised accountability for self (citizen) and system (partners)

Quality across the System

National reviews all highlighted areas for improvement and the centrality of compassion in the care we deliver. We should never be complacent, and we will continue to ask the important questions of those responsible for care so we can all ensure continual improvement.

The following visualises how the System uses its knowledge with checks and balance to bring about consistent quality and improvement.



Patient safety has made great progress over the last 20 years, but there are still instances which are not acceptable, such as the number of inpatient deaths resulting from patient safety incidents per year at 11,000 at a national level[25]. Much more can be done to share safety insight and empower people, both patients and staff with the skills, confidence and mechanisms to improve safety. Addressing these challenges will enable the NHS to achieve its safety vision by building on 2 foundations; a **patient safety culture** and a **patient safety System**.

Three strategic aims will support the development of these foundations, how they work together is shown in figure 29:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole System (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

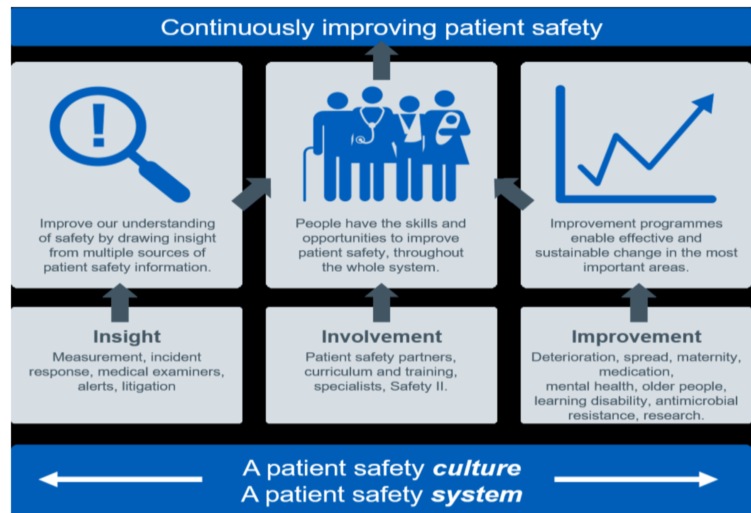


Figure 29

Our work plan embeds the principles of a safety culture within and across local System organisations through transparent sharing and learning, using digital opportunities where appropriate and implementing the Patient Safety Incident Management System to support our advances. Our diverse and skilled workforce represents our best opportunity to deliver the vision for patient safety. We will have an effective strategy for safety improvement to support our staff in keeping patients safe and play our part in focusing on System solutions and strive to avoid creating an inconsistency of informing staff of errors while offering no solution to existing risks.

Transparent Sharing and Learning: developing a learning System

What will look and feel different	By when
Open and transparent sharing and learning	Ongoing development
Development of fully integrated local System quality meetings and incident panels at ICP level	April 2021
Review of current processes through transition in advance of the launch of the new Patient Safety Incident Management System (PSIMS) from April 2020; learning from early adopter sites	March 2021
ICS Learning Events: themes and trends from Serious Incidents, mortality reviews (to include CDOP, LeDeR, ambulance mortality reviews and, medical examiner scrutiny of non-coronial deaths) complaints, safeguarding	Ongoing with full implementation by April 2021
Local Quality Surveillance Group (Joint Intelligence Group) to share hard and soft intelligence to identify and triangulate System pressures and issues; identify	November 2019

[25] Hogan et al's studies

What will look and feel different	By when
pathways requiring routine or enhanced surveillance; inclusive of health and social care commissioned services	
Leadership for Improvement Programmes and System development	April 2020
Development of an integrated ICS dashboard and joint reporting to enable a 'single version of the truth'	March 2020
System assurance and developing architecture; System Quality and Performance Board attended by all System partners	November 2019
System risk management and ownership; focus on the two biggest quality risks relating to workforce and digital	April 2020
Continuous focus on improvement and transformation	Ongoing
System response and gap analysis following publication of the new Patient Safety Incident Response Framework to develop the right skills, Systems, processes and behaviours throughout the health and social care System.	June 2021
Patient and citizen representation and engagement is key in all areas and in line with development of a national a framework to standardise and improve patient involvement in patient safety. Patient representatives are currently engaged in the Quality and Performance Board and the SI Panels with a view to replicating on all safety-related committees by April 2021	April 2021

Transformation and quality improvement in Surrey Heartlands
System service transformation is currently taking place at organisation, ICP and Surrey-wide. Our ambition is that Surrey Heartlands System transformation work applies a quality improvement approach to ensure robustness of identifying what to change, is intrinsically designed to evidence that change and to react swiftly to recalibrate where necessary. We know that the new Quality Assurance and Improvement framework will bring a quality improvement focus by taking action earlier to bring about better quality of care (figure 30).

Figure 30

The Surrey Heartlands System has established a local quality surveillance group; the Joint Intelligence Group. The group is currently reviewing pathway definitions to support routine and enhanced surveillance with a view to targeting improvement support and focus and establishing early warning flags for care provision at both place and scale.

Quality Concerns Trigger Tool
To support delivery this ICS quality strategy, the Academy is focusing on the quality improvement element particularly how it relates to accelerating service transformation to meet System ambitions.

To improve the health and care of the citizens of Surrey through accelerated service transformation we need to:

- Embed quality improvement methodologies in our change work
- Increase the pace of transformation

The diagram in figure 31, articulates the Quality Improvement drivers in Surrey Heartlands.

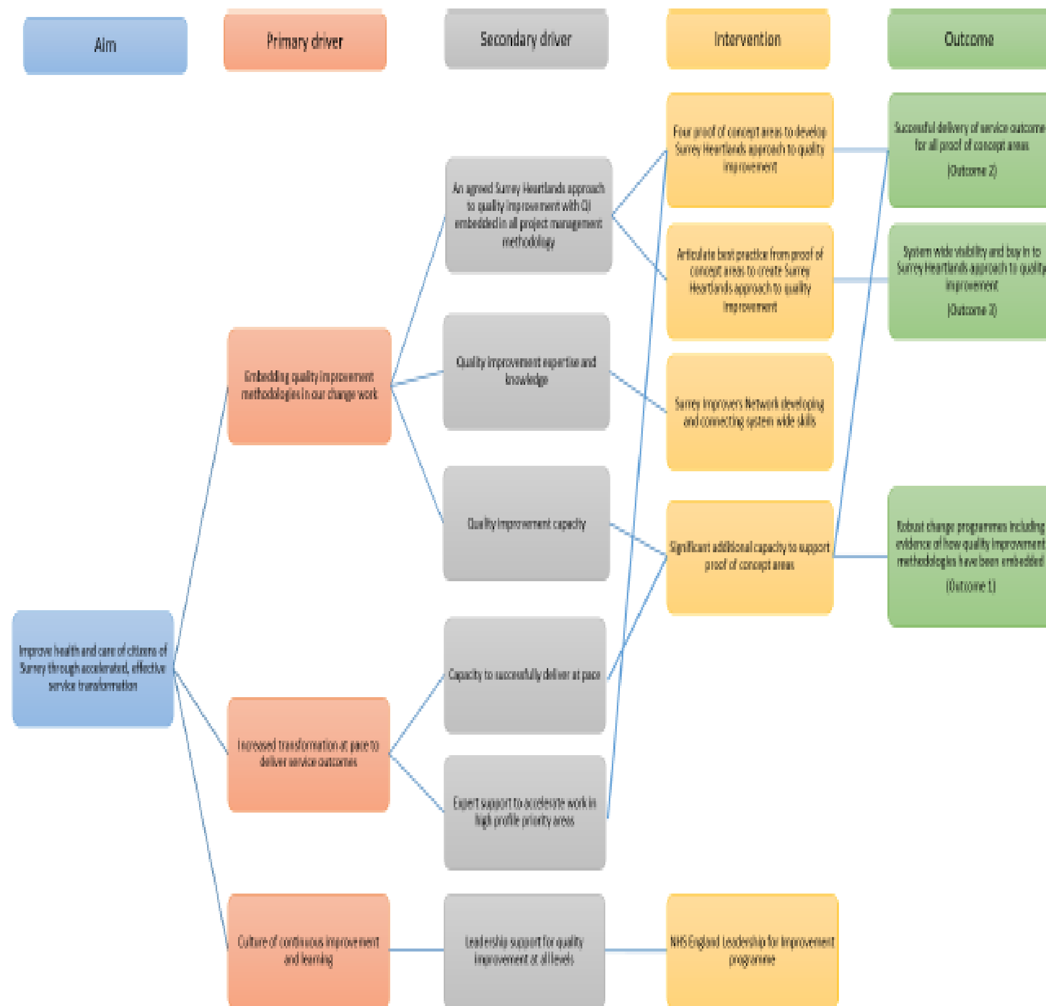


Figure 31

Quality and Equality Impact Assessment

Surrey Heartlands CCGs are committed to ensuring that commissioning decisions, business cases and any other significant plans and strategies are appropriately evaluated for their impact on both quality and equality. Individual CCG Quality Impact Assessment policies were brought together into one joint Surrey Heartlands CCGs policy in May 2019.

The objective of this policy is to set out the responsibilities, process and format to be followed when undertaking a Quality and Equality Impact Assessment (QEIA). The purpose of the assessment is to examine the extent to which existing or proposed services, policies, strategies may benefit different members of the community and, where appropriate, prompt the consideration of adjustments. The table in figure 32 summarises the process to which the System adheres.

Standard	Source of Assurance / Timescale	Responsibility
A QEIA should be conducted for all appropriate 'business decisions'.	Scrutiny of papers for meetings. Any business cases / policies submitted without the required supporting documents should be returned for completion before being progressed.	Relevant ICS and ICP Directors
Risk registers contain appropriate risks in relation to the potential impact of 'business decisions'.	Risk registers reviewed on a quarterly basis and presented to relevant Committees	Relevant ICS and ICP Directors
All assessments judged as proposing significant risk must be referred to the relevant ICS and ICP Director for decision regarding escalation.	Risk register and QEIA	Relevant ICS and ICP Directors

Figure 32

QEIA is a continuous process to help decision makers think through and understand the consequences of 'business decisions'; undertaken as part of the development and proposal stage, along with a review on initiation and following any significant changes following implementation. The chart in figure 33 is an overview of the escalation process for arising quality concerns which is applied across the South East.

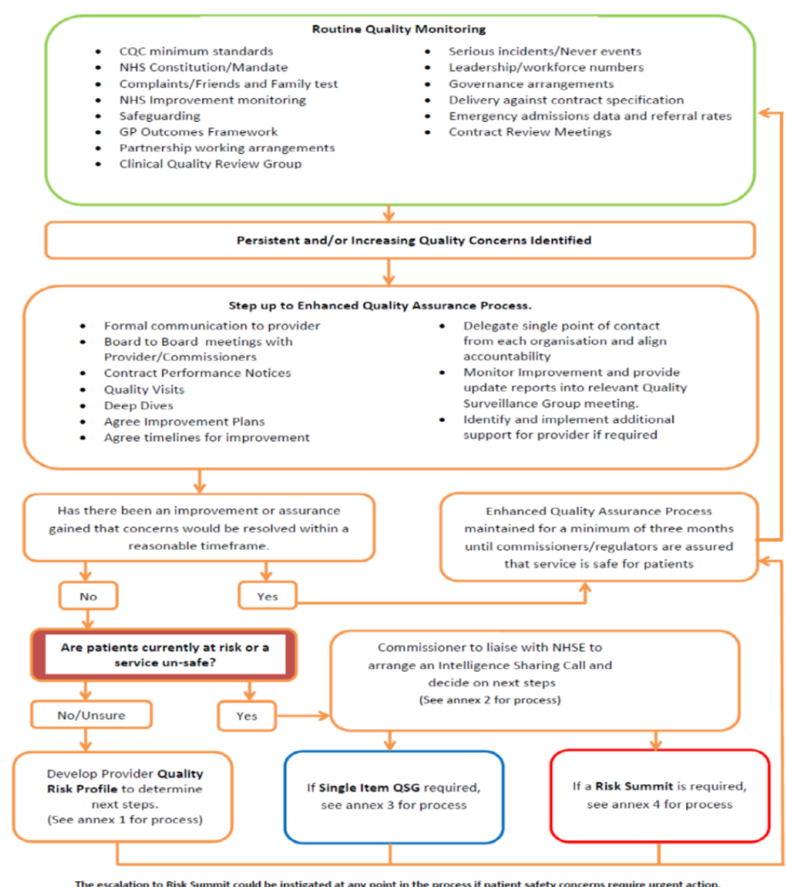


Figure 33

The Academy

A System level enabling body to support clinicians and integrated care partners to deliver high quality outcomes by reducing unwarranted variation by the adoption and spread of innovation and best practice and by working beyond organisational boundaries to liberate solutions that will improve outcomes in health and social care.

The Academy is:

- A virtual network supporting health and care practitioners to adopt, share and evaluate innovation, research and best practice
- Reducing unwarranted clinical variation and standardising practice so that Surrey Heartlands citizens can expect the same levels of care and outcomes no matter where they live
- Helping to create and establish a culture and environment for generating ideas and then putting them into practice to benefit the Surrey Heartlands' population
- Facilitating training and development opportunities.

This is visualised in the figure 34 which identifies the pillars that form the Academy.

Figure 34

The Academy leadership pillar focuses on supporting the transformation work in the system to reduce unwarranted clinical variation. Initially the focus has been on developing system leaders throughout our geography in a consistent way and at all levels of the workforce, including through the Academy's development of our Surrey 500 place based collaborative leadership programme and participation in the national population health development programme. Our aspiration is to link future leadership work to the change work in providing mentorship, support to change culture and collaboration skills in current variation hotspots.

To support this, the Academy have developed a "Connect" model (building on our citizen engagement model) of a workforce panel and ambassador programme to link and support two way communications between workforce teams across the system and change programmes. The further development will include facilitating interactions further using innovative technology platforms to share information and conversations.

The key areas of work the Academy leads on for the system are:

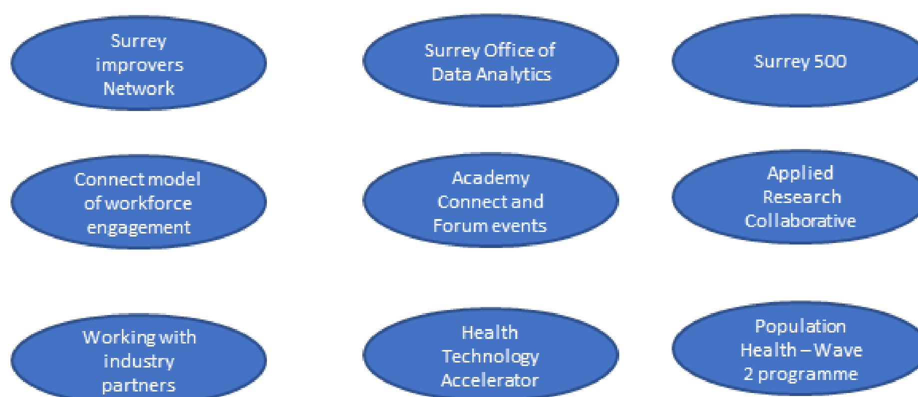


Figure 35

We expect citizens to see over the next 5 years:

- Leadership: A well led System with excellent System leaders who are creative, compassionate and adaptive.
- Improvement: Accelerated change for the benefit of our citizens because we are excellent drivers of change
- Knowledge: The System needs and uses knowledge to make better decisions about people and resources to deliver outstanding care to our citizens.
- Connection: The System strengthened by connecting the System wide workforce to each other and to the work in hand.
- Innovation: The System maintaining the leading edge by underpinning our work with innovation, research and commercial development

It is the Academy's expectation that our Partners will work closely with research delivery partners including the CRN, RDS and Academic Health Science Networks (AHSN) to increase **public and patient participation in research**. The local System "research into practice" strategy will be co-developed through the Academy led by the Executive Clinical Director. Through active participation in delivery of the Applied Research Collaborative (ARC) programme, we will contribute to the national ambitions to increase patient and public participation in research. This work will be formed by local priorities based on JSNA and desktop research and ARC priorities previously consulted on and agreed with constituent bodies.

We are continuing to build on the accelerated work to test innovations through the identification of needs, validation and spread of innovation executed by the AHSN delivery teams working in close partnership with the Academy. This is based on desktop research, active engagement with clinical teams and establishment of an innovation leads network, the AHSN will work in a structured yet pragmatic way to identify need and co-ordinate rapid cycle validation of innovation in real world settings. A £1.6 m investment from EM3 LEP will contribute towards creating an innovation lab on University of Surrey Hospital site enabling rapid testing and validation of innovations.

We will ensure local adoption and spread of proven innovations between organisations through the identification of needs, validation and spread of innovation by AHSN delivery teams working in close partnership with the Academy.

A framework for Expert Leadership Model has been developed. The framework describes a triumvirate of representative clinical and professional groups made up from e.g. Nurses, AHPs, Doctors, Healthcare Scientists, Midwives, Pharmacists, Psychologists, Social workers. Suggests that

having recognisable structures such as triumvirates allows for consistency in leadership at scale and place. For the framework to reflect the Surrey Heartlands systems leadership approach and to harness outcomes for children people with a learning disability and mental health it needs to focus on collaborative leadership across the system and sectors such as employment, education, voluntary sector and expertise by experience, building relationships with peers to support the co-creation of solutions. In designing the framework for Children, Learning Disability and Mental Health it will be important to consider how the Long term plan commitments are led at scale and delivered at place.

A strong start in life for children and young people

First 1,000 days

*By March 2024, we will work with children and families of Surrey Heartlands to ensure that every child has an optimal start, enabling them to enjoy a healthy life where they feel safe, confident and are able to fulfil their potential. The **first 1000 days**, roughly from pregnancy to two years, is a critical phase in child development, and we are committed to working across the System to ensure that families have access to the care that they need. The Local Maternity System (LMS) will work to plan services that have been co-designed and co-produced with women, ensuring that they are responsive to the needs of our local families, and focused on delivering personalised & safe care. Throughout Surrey Heartlands, teams of staff will work together to deliver seamless care across our communities.*

A whole System event launched Surrey Heartlands 'First 1000 Days' focus, bringing together partners from the statutory and third sector, and providing an opportunity to listen to the experiences of local parents and families in 2018.

A number of key themes arose from this event and we are working as a System to develop plans for these areas with parents and families to test on-going plans which are shown in figure 36.

Key themes	Health and Wellbeing Outcomes supported
Access to consistent, reliable, System wide information	Clear, evidence based information is given to all parents/carers to support the prevention of disease through vaccination and early diagnosis
	People have a healthy weight and are active
Effective communication; both between professionals and professional to family	Substance misuse (drugs/alcohol) is low
Support networks & isolation	Clear pathways of communication between professionals
Feeding support	People with depression and anxiety are identified early and supported
	No-one in Surrey feels isolated

Figure 36

The Local Maternity System

Local Maternity Service transformation is pivotal within our first 1000 day pathway. The LMS is the mechanism through which the Surrey Heartlands Women's and Children's Programme is working collaboratively to implement services that are high quality, safe, sustainable and personalised with improved experience and outcomes for women, babies and their families. By working together in this way, the LMS enables local providers to offer joined-up services to improve care and outcomes for women and babies. By 2020/21 we will have implemented our vision, based on the principles of the National Maternity Transformation Programme (*Better Births* 2016) and the NHS Long Term Plan (2019). Details of this work can be viewed in the Surrey Heartlands' Maternity Transformation Plan (appendix 10).

Key Achievements delivered within the first two years of the LMS include the development of a System wide advice line, Single Electronic Maternity Record, Maternity Voices Partnership (MVP) on interview panels and System wide partnership in place to lead wider change across first 1000 days (for example midwife to HV pathways, hub working).

Leadership

The LMS is supported by robust and committed leadership to drive to transformation. There are named clinical leads and safety champions in each 'place' ICP which provides high quality, safe, personalised sustainable and improved maternity service for women, babies and their families.

Governance

The Surrey Heartlands LMS is chaired by the Women and Children's Programme Clinical Lead, and has a membership from across the System, including the MVP lead, Service Leaders & senior clinicians from Maternity services, LMS Clinical & PMO team, Commissioners, Community partners, CCG Quality Leads, Public Health, GPs, South East Clinical Network (Maternity & Neonates). Figure 37 shows the LMS governance structure.

The Board meets bi-monthly and is monitored by the Surrey at Scale ICP Board. Regular highlight reports are produced for the ICS Delivery Board and the Children's Executive Group; capturing risks and mitigating factors against objectives and delivery trajectories.

National monitoring of local maternity transformation provides another conduit to update on progress, identify areas of challenge and support from the national team. Working with our clinical network is an opportunity to learn and share across the LMS footprint.

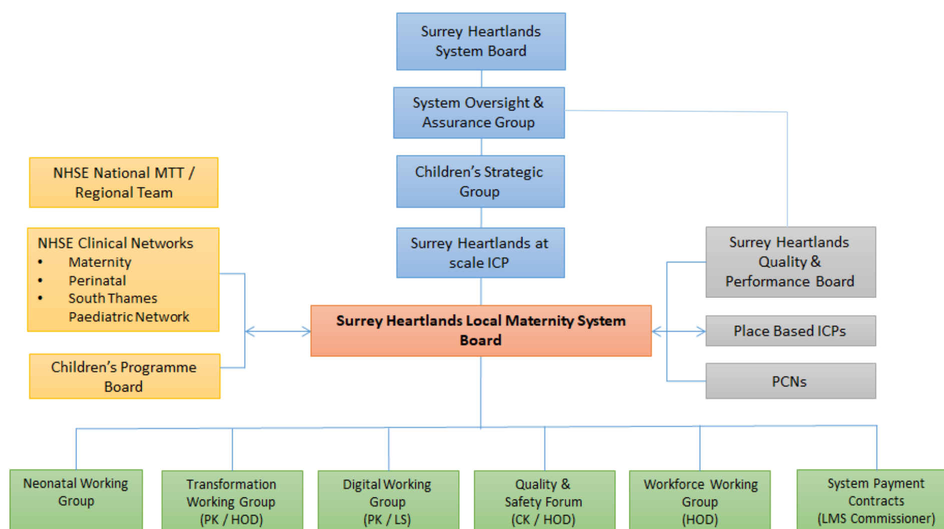


Figure 37

Population Profile

There were 9,241 live births in the maternity units within Surrey Heartlands in 2015/16. The national average of births in 2015 was 62.5 per 1,000 population this varies across the ICS footprint with 53 per 1,000 in Guildford and Waverley CCG, 64 per 1,000 in Surrey Downs CCG and 70 per 1,000 in North West Surrey CCG. There is an increase in the projected numbers of children under one in Surrey; this is due to net migration rather than an increase in births.

29.9% of women giving birth in Surrey Heartlands 2012/13 were aged 35 or above, this has risen to 31.3% in 2015 and which compares to 19.2% nationally in 2012/13. Whilst Surrey's number of teenage

pregnancies continues to reduce and is below the national average, there is clear geographical difference and many young parents have a wide range of risk factors for social care intervention. Over 60% of pregnancies in young people result in termination, this is higher than seen nationally.

Percentage of births to mothers from Black and Minority Ethnic (BME) groups in 2015/16 was 10.2% in Guildford and Waverley CCG, 23.5% in North West, 27.9% in Surrey Downs and East Surrey 18%[26] this compares with nationally 29.8% and in the South East of 20.2%.

Whilst Surrey compares favourably to the national figures for women smoking at time of birth, when we look at the numbers, we can see that there is still work to do as shown in figure 38.

Continue to reduce smoking in pregnancy as part of the plan to reduce stillbirths across SH			
CCG	**% Smoking at time of birth (2016/17)**	**Maternity Unit**	**Activity**
G&W	5.4%	RSCH	2018/19 financial year we had 212 smokers at booking (7%) and this reduced to 182 smokers at time of delivery (6%).
NW Surrey	5.6%	ASPH	2018/19 smoking at booking rate is 6.84% and smoking at delivery rate 5.9%
Surrey Downs	4.6%	ESTH	Annual (2018) smoking at booking 315 women (7.16%) and smoking at delivery 227 women (5.16%).
East Surrey	6.55%	SASH	

National and local aspirations

- Universal Carbon Monoxide (CO) screening for all pregnant women as per NICE guidance (opt-out pathway). Smoking at time of delivery SH 5.8% compared to England which is 10.6% (NHS Digital 2018/19). The national aspiration is to be below 6% however 4.3% of women's status is unknown so we are focussing on improving our questioning and recording of smoking status at time of birth to give a more accurate picture. We are also working on smoking cessation support for women and their partners.
- Clear referral pathways to stop smoking service with developments across the LMs to support partners with smoking cessation.
- Training for all midwifery teams on smoking in pregnancy. Across the LMS Midwives receive yearly mandatory which includes updates from Smoking Cessation links workers.
- Ensure our maternity departments and children's community health provider maintain level 3 BFI status. We also aim to extend this to NICUs.
- Ensure timely access to contraceptive services and assess options for provision within maternity units or other tested models.
- Develop a mechanism for all maternity units whereby A&E attendance is checked for any woman who books with them (to pick up any undisclosed alcohol/drug use and domestic violence
- Review evidence based good practice to assess alcohol use at booking and ensure robust pathway to relevant support services, including Fetal Alcohol Syndrome

Figure 38

The 2014/15 numbers **of breastfeeding initiation (Public Health Outcomes Framework) across Surrey, were above the national average at 85% (England 75%). Initial breastfeeding duration[27] is currently 57.8% (England 43%).**

[26] 2018/19
[27] At 6-8 weeks; Health Visitor Mandated Dataset

Overview of maternity and neonatal services

CCG	Acute Trust	Obstetric Unit	Midwifery Led Unit	NICU	Community Trust	Mental Health Trust	Local Authority	Ambulance Trust
Guildford & Waverley CCG	Royal Surrey Foundation Trust	Royal Surrey Hospital	Royal Surrey co-located	Level 1 SCBU	CSH through CFHS Contract	SABP	Surrey CC	SECAMB
North West Surrey CCG	Ashford & St Peter's NHS Foundation Trust	St Peter's Hospital	St Peter's along-side	Level 3 NICU HDU SCBU	CSH through CFHS Contract	SABP	Surrey CC	SECAMB
Surrey Downs CCG	Epsom & St Helier NHS Foundation Trust	Epsom Hospital	Epsom co-located	Level 1 SCBU	CSH through CFHS Contract	SABP	Surrey CC	SECAMB
East Surrey CCG	Surrey & Sussex NHS Foundation Trust	East Surrey Hospital	East Surrey Hospital co-located	Level 2 HDU SCBU	FCHC through CFHS Contract	SABP	Surrey CC	SECAMB

Continuity of Care

Delivery focusses on increasing the number of women who receive continuity of care (C of C) across their maternity journey, with Trusts working to deliver 35% C of C in March 2020 and over 50% in March 2021. This involves maternity services fundamentally changing the way their midwives work, with small teams of 6-8 midwives grouping together to provide all the care for women in certain geographies. Work is focusing on delivering and supporting staff with new ways of working. The System is currently challenged by staffing shortfall (vacancies and maternity leave) which is being managed through Trust Boards.

Continuity of care is particularly beneficial to vulnerable women, and we are developing how this group can be supported through C of C models throughout 2020/21 to support delivery of the national target of 75% BMAE women receiving C of C by March 2024. 'Pregnancy Circles', a trial of group antenatal care targeted to vulnerable women is being tested at 2 Trusts during 2019/20 & 2020/21 and we will use the outcomes of this research to further guide our approach to supporting women. We have a dedicated midwifery team working in prisons and a learning disability midwife that is supporting the development of care for vulnerable groups of women.

Still Births and Neonatal Death

Achieving national targets to reduce (50% by 2025) Still Birth and Neonatal Death is central to improving outcomes. Alongside improving delivery of C of C, the local System has invested in Masterclass training to support enhanced Cardiotocography (CTG) monitoring and dedicated Fetal Wellbeing midwife posts to lead the change. Improving Neonatal Care at a local level will be led through an emerging Neonatal Sub Group, focussed on delivering the change described in the National Neonatal Critical Care Review (September 2019), with particular focus on local capacity, staffing & training. A local action plan will be developed for delivery from 2020 to 2025. National money is expected to support local delivery during 2020-2021.

The LMS will be working with providers to review their provision of post-natal physiotherapy and develop a consistent high quality offer, enabling women to recover effectively post-delivery. A plan for this will be delivered in 2020.

National Maternal and Neonatal Health Safety Collaborative

All acute Trusts are currently participating in Wave 3 of Maternity Neonatal programme. Focus on smoking cessation and early identification of the deteriorating mother and baby. A number of

interventions are in place such as bedside resuscitation of the very preterm infant, introduction of Kaiser Permanente sepsis risk calculator and interventions to increase Carbon Monoxide (CO) screening during pregnancy and the postnatal period.

The LMS Neonatal sub group was established in October 2019. Lessons learned and sharing of themes from mortality reviews will pass through this forum. Membership includes NN representation from all Trusts, CDOP/PHE and NNODN Lead.

As an LMS, we have invested in fetal wellbeing support for our Trusts. Part of this programme included provision of an international expert to present and share learning across the LMS on the benefits of physiological fetal heart rate interpretation. As a result, all Trusts are now committed to taking the next steps in transforming their clinical practice into new ways of working. The first Trust plans to commence this work by January 2020, with an expected timeframe of 18 months.

Saving Babies' Lives Care Bundle
As part of the roll out the care bundle across maternity units we have undertaken a comprehensive Gap Analysis of all elements across the Trusts in May 2019. Current Gaps include:

- increase staff completing 'Very Brief Advice' training to support women to understand the risks of smoking in pregnancy
- implementation of 'Fresh Ears' System for intermittent auscultation
- implementation of CO monitoring at 36 weeks - this is being addressed by the Maternity Neonatal project and will be in place by March 2020
- provision of preterm birth clinic

LMS Funding has been provided to all Trusts for 1 year to support of 0.4 WTE fetal monitoring midwife, 1 Trust recruited, recruitment underway in the other 2 Trusts. Expected to be in place by Dec 2019.

NHSE SBLCB refreshed survey has been received by Trusts due for submission November 2019. LMS Governance Lead to work with Trusts to support submission, this survey aligns well with Gap analysis undertaken within the LMS. The LMS is coordinating the SBL Training fund for £10k to support further training. Local discussions are taking place and the training will have a direct impact on closing the identified gaps.

Focusing on preventing pre-term births
Local Data collection for preterm births ongoing – for monitoring via LMS dashboard. LMS Governance Midwife attendance at NNODN meetings from September 2019 to improve collaboration with NeoNatal network across KSS. All Trusts have specialist pre-term birth clinics. Discussions underway with neighbouring Trusts to agree any collaboration and agree transfer process in an emergency.

LMS wide funding submission to AHSN for implementation of placental growth factor (PlGF) testing in all Trusts. To align test across Surrey Heartlands. Funding submission due end October 2019.

Accredited, evidence-based infant feeding programmes
ASPH have 'sustainable' Baby Friendly Initiative (BFI) level, RSCH and Epsom have BFI Gold accreditation. East Surrey maternity unit and their neonatal unit have achieved Stage 2 and are going for Stage 3 next spring (2020). During 2019/20 & 2020/21, we will be working on BFI accreditation for neonatal units and Higher Education Institutions. Transformation funding has been agreed to support BFI training to GP's.

Improve the safety and effectiveness of services and experience of families
We have formed a neonatal working subgroup of the LMS which first met in Sept 2019. We are awaiting the neonatal critical care review, due for publication imminently. Estimating future capacity

requirements for neonatal critical care is challenging given the falling birth rates across Surrey Heartlands. Given the great difficulties in recruiting and retaining middle grade paediatric and neonatal doctors in particular, we anticipate that the Neonatal Critical Care Review will necessitate addressing where each level of neonatal care is most safely, efficiently and sustainably delivered. In addition, we are reviewing our affordability to support dedicated neonatal workstream leadership.

We are confident that parents are involved in the care of their babies across Surrey Heartlands. We are awaiting further guidance from the Neonatal Critical Care Review and will then carry out a baseline assessment to estimate our future requirements. We will work closely with the South East Neonatal Network, (ODN), on the development of care coordinator roles where appropriate. All units receive FFT feedback. RSCH is having a refurbishment and there will be parent bed beside each cot. SASH is also undergoing refurbishment (TBC if this will include parent beds).

Choice and Personalisation

Where we are now

- Women have a range of high quality and safe birth options across the LMS ranging from a dedicated home birth team, midwifery led units and obstetric/neonatal input where required
- The introduction of BadgerNet an LMS System-wide maternity record that women can access from their phones or computer support women to access their own maternity health records.

Our ambitions for personalisation

- Surrey Heartlands LMS is committed to ensuring that services are responsive to the needs of women and their families with choice and personalisation streams
- A directory of local information will also support women in being aware of what is available in their area and enhanced personal choice.
- Surrey Heartlands ambition for personalisation includes having a skilled dedicated workforce who will support women to develop personalised care plans to ensure that maternity care is equitable and meets women's specific needs.
- Women can access timely unbiased information enabling them to make choices / decisions about their maternity care.

Action Plan

- Enable women to use personalisation plans, birth plans and enter their choices on Badgernet; this should be delivered by March 2020
- Share importance of personalisation so it becomes a real choice for women

Prevention

The LMS is working with Public Health to develop a dedicated Prevention Plan to include a pre-conception strategy. A business case has been approved to develop a weight management support offer to pregnant women, supporting weight management and health in pregnancy and health, nutrition, baby feeding, weaning and family food education to support them as they progress on their journey through family life. It is anticipated that this offer will go live during 2020. We are targeting engagement with communities to improve understanding and take-up of childhood immunisations for the under 5s.

Promotion of flu vaccinations at antenatal appointments and in maternity units

Unit	Activity	Aspiration
RSCH	2018/19 financial year 1518 Flu vaccines (54%).	Aspirations for next year are to offer vaccine clinics in maternity hubs to encourage greater uptake.
ASPH	ASPH did not provide a flu vaccine service in maternity in 2018-19; flu vaccine was promoted but was delivered by primary care.	2019-20 A maternity immunisation programme has been started and vaccines are offered at Ashford Community Hub and St Peters Antenatal clinic.
ESTH	Information captured after going live with BadgerNet: 17th October 2018 to 16th October 2019, 330 (6.90%) flu vaccinations in this period.	Continue to promote flu vaccinations within the unit and community within the development of community hubs.

Figure 39

Where we are now

An LMS Prevention Plan is in development to include detail across the following:

- There are a number of strategic transformation programmes in Surrey Heartlands; Early Help SEND and Children's Community Health provision, elements of which require aligning to ensure opportunities are realised
- The development of Community Hubs will enable alignment with the emerging Local Family Partnerships a cornerstone of the Surrey Early Help System. This will help to ensure families have access to wider support within the community, including housing, early year's education and welfare/income advice and services
- We will continue to promote key, easily accessible public health messages and encourage approaches such as Making Every Contact Count. This will then form a basis for testing and establishing pathways, through a model of Social Prescribing to services that can support health and wellbeing in both the ante and post-natal periods
- Promote flu vaccination at antenatal appointments and in maternity units (figure 39)
- Maximise uptake of vaccination for whooping cough by 32 weeks gestation
- Ensure 100% offer of antenatal screening programmes to all women
- Continue to reduce smoking in pregnancy as part of plan to reduce stillbirths across Surrey Heartlands (figure 38)
- Universal CO screening for all pregnant women as per NICE guidance (opt-out pathway)
- Clear referral pathways to stop smoking service
- Training for all midwifery teams on smoking in pregnancy
- Ensure our maternity departments and children's community health provider maintain level 3 BFI status. We also aim to extend this to NICUs
- Ensure timely access to contraceptive services and assess options for provision within maternity units or other tested models
- Develop a mechanism for all maternity units whereby A&E attendance is checked for any woman who books with them (to pick up any undisclosed alcohol/drug use and domestic violence)
- Review evidence based good practice to assess alcohol use at booking and ensure robust pathway to relevant support services, including Fetal Alcohol Syndrome

Our ambitions for prevention

- To have a bespoke LMS prevention plan jointly led by Public Health and the LMS team
- Plan will be integrated across First 1000 days

Action Plan

- Gap analysis in progress across all areas of prevention
- Working group with LMS lead in place in conjunction with Public Health

Perinatal Mental Health

The new Perinatal Mental Health Service started October 2018, having recruited and developed a multi-disciplinary team to support women as close to their homes as possible, providing a good experience that is measurably effective and increase psychological interventions within the service. Antenatal Service PNMH clinics run alongside specialist midwives and obstetricians. Teaching sessions to develop this include; maternity safeguarding, world mental health day training day suicide awareness and liaison psychiatry training day.

Where we are now

- Rolling programme of training events for health visitors, IAPT staff, GPs and others to increase understanding and awareness around maternal mental health
- The proposal was developed staffing requirements based on:
  - RCPsych recommendations around the number of live births
  - Geographical and practical considerations

  - Current provision of our Parent Infant Mental Health Service
  - Feedback from perinatal specialist midwives about the interventions they believe would be the most beneficial. This included a strong focus on the need for specialist medical input and psychology, which has led to increasing this aspect of the service and balancing this by reductions in other areas such as nursing/OT provision
- In addition to treating mental health problems, a key objective will be to promote the relationship between mother and child, supporting the wellbeing of the infant.
- The service is also already identifying partners and offering information and signposting advice for support. Leadership and further clinical training is being expanded in 2020/21 to support the service workforce expansion that is being planned for subsequent years. Clinical stratification is being worked through across the PNMH networks to support the expansion from 12 - 24 months intervention support for people that require this.
- There will also provide training to up skill other health professionals in perinatal issues, including GPs and health visitors. This will:
  - Raise awareness of perinatal mental health, including safeguarding and support for families
  - Improve confidence in detecting and referring/treating women
  - Raise awareness of the referral pathways
- This proposal has been worked up with full collaboration with local partners and the service model co-designed and consulted on by service users
- The new specialist unit, which will be based in Kent, will mean that women from across Kent, Surrey and Sussex who experience mental ill health during pregnancy, or in the year after birth, will be able to get the support and care they need while also continuing to be with their baby.
- First Perinatal CCQI Peer Review took place in February 2019 and it was clear that the team have plans in place to meet unmet and partly met PQN standards
- 100% of women asked would agree or strongly agree that they would recommend the service to others

Our ambitions for perinatal mental health care

- **Improved access*:*** the service enhances provision and enable more women to access treatment close to where they live. With agreed pathways, health and care professionals will be able to refer people into the service and receive expert help and advice in a timely manner.
- **Positive experience:** care and support from a specialist team will enhance patient experience. Existing provision - including GPs, IAPT and community mental health teams - will provide wrap around support for those with mild to moderate problems.
- **Earlier diagnosis and intervention:** our training programme will educate and up skill, other health and care staff to recognise and respond to the signs of perinatal mental ill health. This will help to ensure that more women are referred and signposted to receive the help they need.
- **Awareness, openness and transparency**: With the support of the broader network, we will implement a communications plan to promote the service and reduce stigma, including developing web content and literature to provide to all women about wellbeing during pregnancy.

Action Plan

- Actively contribute to Perinatal Mental Health Working Group.
- Ensure System is in place for health professionals to access and share information in particular relating to up to date risk assessments, care plans and birth plans for women identified as having perinatal mental health needs

Safer Care

Where we are now

- Full trajectories for stillbirth, neonatal and maternal mortality and serious brain injury.
- Implemented a LMS Safety Forum

- Trajectories in newly developed LMS dashboard, monitored at LMS Board
- LMS wide sharing from incidents
- Gap Analysis for Savings Babies Lives Bundle 2 completed
- LMS funded enhanced CTG interpretation masterclass for all clinicians
- Funded Fetal Wellbeing Midwife in Trusts to support local improvement
- Current gap analysis around the bereavement pathway
- Applying learning from HSIB
- Accountability at Board level for CNST compliance
- Smoke-free pregnancy pathway
- Development of Neonatal Sub-group
- All Trusts have implemented use of Perinatal Mortality Review Tool.
- LMS Governance Lead; membership of NHSI Maternity and Neonatal Clinical Improvement Leaders Group
- All 3 Trusts are currently participating in Wave 3 of Mat Neo programme.
- Introduction of Kaiser Permanente sepsis risk calculator

Our ambitions for delivering Safer Care

- Ensure continuous improvement in clinical outcomes – monitored through LMS Dashboard at the Quality & Safety Committee and the LMS Board

Action Plan

- Work with local networks that will develop a Maternal Medicine service offer
- Continue to work with Regional and National teams, to learn from colleagues and maintain a positive change culture
- Continue to share local benchmarking against national standards with Executive Boards

Co-production with women and families

Co-production is a central part of maternity transformation. Service Users have had the opportunity to co-design and co-produce the on the ambitions for transformed maternity services. This has been achieved through several channels. The development of a Maternity Transformation Newsletter helped to keep service users abreast of progress and provided a conduit for them to be involved in the developing maternity services.

SH LMS Embedding Maternity Transformation Conference (January 2019) had representation from the local MVPs and a Whose Shoes held in the Spring for Service Users provided an opportunity for women and their families to influence service provision and shape new models of midwifery care. The Maternity Voices Partnership is actively involved in walking the patch at provider sights providing insight to women and their families' experience of maternity services.

LMS Funding

LMS Transformation funding is allocated to support delivery across the key deliverables, particularly focussing on transformation and clinical leadership in Acute Trusts, Programme Leadership, supporting engagement, safety and governance leadership, digital leadership, development of community hubs, local fetal wellbeing leadership and development.

Workforce

Surrey Heartlands in engaged with the KSS workforce development, focussed on supporting the delivery of Continuity of Carer and developing the maternity support worker role to ensure consistent training and competencies & and appropriate career structure.

We are awaiting relevant recommendations which may be in the Neonatal Critical Care Review. We have formed close links with the South East Neonatal Network (ODN). Providers are determining their training needs for neonatal nurses by March 2020.

Digital Access to access maternity notes and information

Badgernet is in use across three of the four acute trusts with a full electronic patient record for women with smart phone access. Planning will take place to support the implementation of an electronic record at SASH with a view to bring consistency across the LMS by 2022. A gestational diabetes app is in use at RSCH and in the process of implementation at ESH and ASPH. The LMS are planning to develop a single information platform to consistent and high quality information for users, supporting women's choice.

A single System wide information platform is under construction going live in 2020 that will allow shared consistent information provision and signposting to pregnant women and their families.

Delivery Plan Trajectories

	2020/21	2021/22	2022/23	2023/24	Comments
The number of stillbirths during a calendar year	34	31	31	29	Data adjusted to incorporate SASH from 2020/21. SASH's baseline comprises of 15 still births from 4,461 births in 2016.
The number of live births and stillbirths occurring during a calendar year	14,034	14,034	14,034	14,034	
Rate per 1,000 live births and still births	**2.42**	**2.21**	**2.21**	**2.07**	Due to the local fluctuation in birth rates, trajectories are modelled on a static birth rate (2016).
The number of neonatal deaths during a calendar year	16	15	14	13	Data adjusted to incorporate SASH from 20/21. 0 NND in 2016, Live births 14029. Denominator descriptor amended as should not include stillbirths. Changes to classification of NND in 2019/20 will affect rates - more NND's recorded under new definition.
The number of live births occurring during a calendar year	14,029	14,029	14,029	14,029	
Rate per 1,000 live births	**1.14**	**1.07**	**1.00**	**0.93**	
Number of women who reach 29 weeks gestation in March, who are marked as being on a continuity of carer pathway, and have a named lead midwife and team as part of their maternity care plan.	9,573	14,034	14,034	14,034	Baseline from 18/19 Data adjusted to include SASH from 20/21
Number of women who reach 29 weeks gestation in March.	3,400	7160	7160	7160	
%	**35.52%**	**51.02%**	**51.02%**	**51.02%**	
The annual number of infants who received at least one episode of care within a neonatal unit in England with a brain injury occurring during or soon after birth, without exclusions	27	32	30	28	SASH incorporated from 20/21. Data obtained from NN Data Analysis unit. Presumption of 2010 national benchmark of 5.27 upper limit. 2015 national benchmark 5.19. Linear trajectory from 2017 with presumption of static rate since 2015 as no local data to compare
Annual number of live births in England	9,245	14,034	14,034	14,034	
Rate per 1,000 live births	**2.92**	**2.28**	**2.14**	**2.00**	

Figure 40

Every child fulfilling their potential
*By March 2024, we will work with children and families of Surrey Heartlands to ensure that **every child has an optimal start**, enabling them to enjoy a healthy life where they feel safe, confident and are able to fulfil their potential. **We want the percentage of children in care achieving 5A*-C or equivalent GCSEs to increase from the current rate of 17.2% to the 'best in class' rate of 23.9% over the next 10 years and continue to see a reduction in the proportion of 16-17 year olds not in education, employment or training to 3.2% from our current rate of 4.4%.** We recognise we must go further for those who are vulnerable or at risk of health inequalities; to maximise young people's life chances, those special educational needs & disabilities will receive an increased focus as to ensure that everyone is able to fulfil their potential and play an active role in their community. **We want to see a reduction in the number of people with a high anxiety score from our current rate of 20.1% to 15.6%.** We will work with families, careers and young people to provide access to services and support, so that all children have the opportunity to start well, lead healthier, fulfilled lives and positively impact future generations, ensuring that no one is left behind.*

System Development
To ensure best use of both our financial and staff resources we are deepening our partnership relationships and creating structures to ensure System wide design and decision making. As part of this, it is essential that our staff have the opportunities to learn and train together. The Surrey Children's Academy will commence in 2020, bringing the opportunity for staff working with children to train and develop together, developing the ethos of a broad & flexible children's workforce. 100 delegates from the System wide Children's and Families workforce have been brought together as a tranche of the 'Surrey 500', tasked with considering opportunities and barriers for partnership working & suggesting opportunities for further partnership working.

Across the System we are working to support vulnerable families. The dedicated Gypsy, Roma & Traveller Health Visiting service will be expanded to support families who do not have a permanent home, and we are exploring ways to develop peer support networks to empower communities to support themselves from within. This initiative aims to improve information flow, combat isolation and support families to engage with services that might be available to them.

We will work with Public Health to support successful implementation of the newly commissioned children's weight management service and ensure that links are developed with acute paediatric teams and emotional health and wellbeing services to ensure that the most at risk children receive the services that they need.

Special Educational Needs and Disabilities
Local SEND improvement plans focus on System wide commitment to improving the outcomes and experiences of children and families with SEND:

1. Reviewing the local offer, initiating an autism review and developing an Early Years SEND Strategy
2. Improving the local offer; over 2021/22 improving the commissioned offer, delivering better value for money and embedding a graduated response to service delivery, and improving the quality of our service delivery
3. Improving the partnership approach to service development and delivery, integration, shared policies & guidelines.

The shape of the programme, what it will achieve and how it will be measured is shown in figure 41.

Figure 41

Developing Acute Care

We are reforming a Surrey Acute Paediatrics Clinical Reference Group to enable the effective networking of local clinicians and support the development of care locally. Surrey Heartlands is engaged with the South Thames Paediatric Clinical Network and is specifically focussing on the development of consistent pathways for paediatric surgery. The Network will also be leading work to drive change and improvements in the delivery of Paediatric Critical Care, with an initial audit of individual provider's care volumes in autumn 2019. It is likely that over 2020/21 this work will drive recommendations as to the future provision of level 2 critical care for children.

Initial pilots of a children's community hub model (bringing Paediatricians and GPs together to see families with General Paediatric problems in the community to support sharing paediatric knowledge and education in primary care) are ongoing and will be fully evaluated. If successful, it is anticipated that the model will be widely rolled out across 2020/21 & 2021/22.

From 2019/20 we will be working with the newly emerging clinical networks to ensure we improve the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes.

Transition to adult services

Transitions between children's and adult services will be reviewed, selectively moving to a '0-25 years' service where appropriate to improve children's experience of care, outcomes and continuity of care. **By 2028 we aim to move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs,** rather than an arbitrary transition to adult services based on age not need. Discussions will be starting with Community and adult providers regarding transition from child to adult services. Plans to form a CAG involving acute, community and adult services for physical and mental health to discuss and plan changes required.

We await with interest the structure of the emerging National Children's Transformation Programme and develop detailed plans when the 'ask' becomes clearer.

You can read more about Learning Disabilities transition to adult services later in the chapter.

Children and Young People's mental health

*By March 2024, we will work with children and families of Surrey Heartlands to ensure that every child is enabled to enjoy a healthy life where they feel safe, confident and are able to fulfil their potential. We recognise we must go further for those who are vulnerable or at risk of health inequalities; to maximise young people's life chances, those with **mental health needs** will receive an increased focus as to ensure that everyone is able to fulfil their potential and play an active role in their community. We will work with families, careers and young people to provide access to services and support, so that all children have the opportunity to start well, lead healthier, fulfilled lives and positively impact future generations, ensuring that no one is left behind.*

Surrey's Emotional Wellbeing and Mental Health (EWMH) Strategy for Children and Young People (2019-2022)[28] was approved by the Health and Wellbeing Board, following extensive engagement. With information from the Joint Strategic Needs Assessment, provider evaluations and extensive engagement events with stakeholders including children and young people who have experiences of our services, we have worked to understand the mental health and emotional wellbeing needs of children and young people. Young people, parents and carers have asked us to:

- Reduce waiting times for services
- Provide more information for self-help and whilst waiting for treatment
- Make CAMHS available in a variety of different locations
- Help to reduce stigma and increase access to CAMHS; more community services that 'normalise ' the access for help
- Reduce waiting times for diagnosis
- Improve access for diagnosis and support if you had ADHD, Asperger's and ASD
- Design care that is adaptable, flexible and person centred.
- Make it easier to navigate the System

Our plans are set out in detail, in the 2019 refresh of Surrey's Whole System CAMHS Transformation Plan[29]. In our forward planning, we were able to draw on:

- The Children and Young People's Emotional Wellbeing Charter (2018)
- Findings and recommendations from engagement with children, young people, families, professionals and community organisations, led by the Dartington Service Design Lab (2019)
- A Thriving Community of Children and Young People in Surrey; a strategy for their Emotional Wellbeing and Mental Health (2019 - 2022)
- The work of the five Transformation themes, whose work is currently being developed or is already in progress (initial phase autumn 2019 - March 2020)

[28] CYP Emotional Wellbeing Strategy
[29] http://www.guildfordandwaverleyccg.nhs.uk/website/X09413/files/191031-CAMHS_Transformation_Plan_Refresh_Oct_2019_Final_v1_6_2_Surrey.pdf

We have a number of successful and well-regarded services, such as our CAMHS Eating Disorders, HOPE and Hope House and our CYP Havens. The five Transformation themes, which are detailed in our CAMHS local transformation plan are addressing key areas of challenge:

- Access
- Early Intervention
- Vulnerable children
- Crisis
- Social, emotional and mental health (also known as behavioural, emotional and neurodevelopmental)

We expect citizens to see over the next 5 years the following ambitions realised:

Access

- Joint work between SCC, NHS and third sector to Implement one front door that offers multi-agency triage, signposting and advice; **with above national target of 38% for proportion of CYP accessing services by 2023**
- Enable our workforce to provide a graduated and multi-disciplinary response and embed 'getting advice' across services and processes through cross-System leadership
- Ensure that early and emerging concerns are actively identified and families are supported with evidence-based interventions from the first contact including interim support
- Effectively and efficiently deploy skills to manage growing demand, supported by streamlined processes and a shared view of demand, capacity and performance
- Improve digital access to information and support such as virtual counselling
- Establish clear self-referral pathways

Actions which are delivering impacts include:

- Opt in letter process – the team are contacting blocks of 25 historic referrals weekly to ensure a referral is still required. Prioritised recruitment to the CAMHS SPA team
- Investing in upgrades to the referral portal software, RIVIAM
- Updated triage templates on SystemOne with accompanying training delivered
- Working with counselling partners to absorb an increased number of suitable referrals and exploring new self-referral processes to these services
- Working to ensure internal referrals do not go through the SPA.

We expect citizens to see over the next 5 years the following ambitions realised:

Early Intervention

- Increased Primary Mental Health Worker resource for consultation, training and brief interventions linked to schools
- Develop a model to establish all schools to become Emotionally Healthy Schools
- Increase the role for VCS sector, working directly with schools
- Make Schools/GPs more aware of support available for children's wellbeing and mental health within local communities

Crisis

- Establish a full range of services across all relevant agencies for all CYP to support them including a pathway for trauma and emotional regulation
- Establish a multi-agency approach with joint accountability, integrated pathways, improved communication and information sharing and close working with education and criminal justice**.**
- Develop innovative models of care build on best practice to avoid unnecessary admission and support discharge.
- Have shared responsibility for planning, decision-making and the financial approach across the whole pathway**.**

Social & Emotional Mental Health

- Revise the existing Behavioural, Emotional and Neurodevelopmental Pathway
- Link and align with SCC-led SEND improvement plans
- Improving support for CYP/Families in Accelerator Site areas – a geographical cluster of schools in Spelthorne.

Vulnerable children

We are working to ensure victims and perpetrators of domestic abuse experiencing multiple and severe disadvantage access the right services at the right time (i.e. refuges that accept victims with substance misuse issues, and perpetrators receiving support to tackle mental health conditions. We want every child and adult experiencing Domestic Abuse to be seen, safe and heard and free from harm of perpetrator behaviour. This will see Perpetrators are held to account.

We will know this has worked by:

- Increased referrals from primary and acute care to specialist outreach
- Increased number of perpetrators supported to reduce reoffending by addressing substance misuse and mental health
- Increased number of survivors who are self-medicating (drugs/alcohol) accessing the right support as part of integrated support pathway

Managing Demand

To meet the increase in demand on CAMHS from children and young people with anxiety and low mood, we are looking at the development of an Early Intervention Service (using CCG children and young people's mental health investment funds) to work in partnership with our provider of specialist CAMHS so that support can be offered to children and young people more quickly from April 2021.

We are planning the integration of the CAMHS Single Point of Access with the Council's Children's Services Single Point of Access to extend our offer of support for children and young people (and their families) who are seeking help related to emotional wellbeing and mental health. Our ambition is reduce our average waiting time for CAMHS by at least a week each year to move closer to the NHS Long Term Plan ambition of 4 week waiting times for CAMHS.

Future strategic change
Our CAMHS contracts were extended to 31st March 2021, to enable and accelerate System transformation of services prior to procurement. Surrey's transformation plans and progress are shared transparently on our websites, as we implement and evaluate the five transformation themes.

In parallel, SCC and the CCGs as commissioning partners are now in the early stages of the procurement process. Market engagement events are being held in autumn 2019 and early 2020; our communications and engagement work continues as we co-design, develop and refine our new service model for the future.

Using the i-Thrive framework[30], our vision is to shift the focus of service delivery towards earlier support and intervention. Our schools-based approach is being tested through the Accelerator sites. We expect to apply for the next wave of Mental Health Support Teams in summer 2020.

National Priorities

Learning Disabilities and Autism

By March 2024, action will be taken to tackle the causes of morbidity and preventable deaths in people with a ***learning disability*** *and for* ***autistic people****. We aim to work closer together to create a single integrated team across Surrey County Council and the NHS.*

Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, specialist care and working more effectively with people and their families.

The whole NHS will improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing**.** We plan to **increase the rate of people with learning disabilities who are in paid employment from 9.0% to 16.8%**. Following a consultation on the options for delivering awareness training, NHS staff will receive information and training on supporting people with a learning disability and/or autism and reasonable adjustment provision added to contract requirements.

As part of the Transforming Care agenda Surrey has initiated the development of a core Learning disability and autism specialist core team within Surrey County Council and work is underway to develop alignment with the Specialist Community Learning Disability teams, to develop points of integration to support more holistic person centred health and care delivery

Integrated Care Systems (ICSs) will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism. Taking this further, Surrey is developing a quality self-assessment tool based on the NHS Improvement requirements that will be implemented with the relevant contract requirements across all providers.

Health Checks
Receiving regular health checks is an important part of ensuring the ongoing health and wellbeing of our population. For Learning Disabilities, we have set ourselves the following ambitions to achieve this:

- Improve uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability

[30] http://implementingthrive.org/about-us/the-thrive-framework/

- 75% of those eligible have a health check each year, current average is 45%
- Improve the register quality
- Ensure delivery for people in 14-18 category
- Improve on Health action plan (HAP) to target 100% of people who have had a health check will have a HAP as part of the annual review
- initial target 50 % <100% of people who have had an annual health check will have a Health action plan by end of 10 year plan

And for autism:

- Ensure delivery of Autism registers in GP practices
- Introduce a specific health check for people with autism

Surrey Heartlands has an ambition to provide annual health checks to 3,916 citizens with Learning Disabilities by 2023/24 to ensure we reaches at least 75% of the population. Figure 42 shows our trajectory to achieve this over the next 4 years.

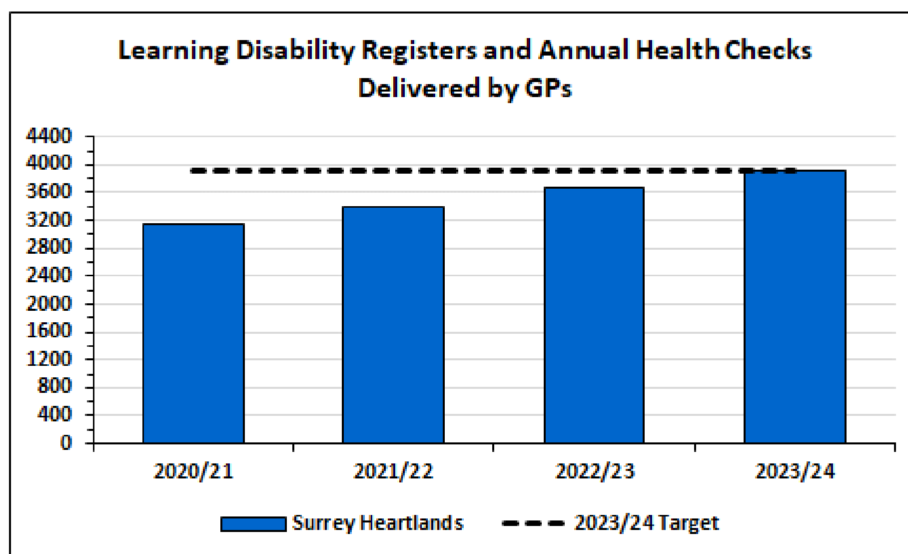


Figure 42

The CCG in Surrey Heartlands will complete an audit of the health needs of people with LD and Autism to understand the key areas of the health need within the Surrey.

We will be expanding the Stopping over medication of people with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the overmedication of people with a learning disability, autism or both. Our Pharmacy team will be working with Care Homes and primary care to review the medications of people with LD and Autism.

We will continue to fund the Learning Disabilities Mortality Review Programme (LeDeR), the first national programme aiming to make improvements to the lives of people with learning disabilities. To accelerate the programme, our LeDer co-ordinator is in post commenced from September 2019. They will facilitate the backlog of review, which will be managed by the CSU. The bank of reviewers has been initiated and will be maintained through the LeDer reviewer network. The commissioned

uplift to the Acute and Primary Liaison services via SABP included the requirement to participate in LeDer reviews.

By 2023/24, a '**digital flag**' in the patient record will ensure staff know a patient has a learning disability or autism. Some of our acute hospitals already have a robust digital flagging system and across Surrey Heartlands, acute hospitals are upgrading their alert systems as part of the implementation of a new electronic patient record system. In other areas of the System, Surrey will work to deliver; flagging on community settings, autism flagging and GP registers, primary care flagging for both LD and Autism to identify reasonable adjustments.

Working with the Department for Education and local authorities to improve awareness of, and support for, children and young people with learning disabilities, autism or both, we will:

- Map local offer
- Check EHCP process and status of each child with SEND
- Ensure delivery of EHCP process to support delivery of additional support for people with LD and or Autism in schools
- Actively work with Preparation for adulthood to include accessing health checks and using primary health care

We will work with partners to bring hearing, sight and dental checks to children and adults with a learning disability, autism or both.

Autism Diagnostic Services
Children and young people with suspected autism wait too long before being provided with a diagnostic assessment. Over the next three years, autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to **reduce waiting times for specialist services**. Our aspiration is to reduce this to 10 weeks from referral to treatment. This is included in the CAMHS transformation work stream.

This will be a step towards achieving timely diagnostic assessments in line with best practice guidelines. Together with local authority children's social care and education services as well as expert charities, we will jointly develop packages to support children with autism or other neurodevelopmental disorders including attention deficit hyperactivity disorder (ADHD) and their families, throughout the diagnostic process. The neurodevelopmental service in Surrey is now providing limited liaison support for people post diagnosis.

By 2023/24 children and young people with a learning disability, autism or both with the most complex needs will have a designated **keyworker**, implementing the recommendation made by Dame Christine Lenehan (Lenehan recommendations).

Initially, keyworker support will be provided to children and young people who are inpatients or at risk of being admitted to hospital. Keyworker support will also be extended to:

- vulnerable children with a learning disability and/or autism
- multiple vulnerabilities
- looked after and adopted children
- children and young people in transition between services

Transforming Care
Local providers will be working in partnership to identify areas for community development that will:

- reduce avoidable admissions
- enable shorter lengths of stay
- reduce out of area placements

Surrey will proactively work with people in existing inpatient beds to manage the admissions of people with Learning Disability and/or Autism to ensure robust assessment and treatment and timely discharge. We will actively work to deliver the Transforming Care requirements so that each person in an inpatient bed will be seen at the following ratio face to face:

- Children in Tier 4 or 52 week placement schools 6 weekly
- Adults in inpatient settings 8 weekly

  This will require additional resource to complete the 116, ½ day assurance visits per year

Due to the increasing community developments Surrey Heartlands will be reducing the number of children in inpatient beds to 3 by 2024. This is being enabled through new care models which are developing community assessment, challenging behaviour pathways and emerging ASD commissioned pathways.

This will work towards and maintaining the Learning Disability Improvement Standard to; reduce length of stay, reduce use of Seclusion, reduce long term segregation, reduce use of restraint, implement 12 point discharge plan and ensure Care and Treatment Reviews (CTR) and Care Education and Treatments Reviews (CETR) delivery.

The CETR and CTR process will be used to ensure robust care delivery for people in inpatient beds. In accordance with the NHSE standard, children receive care delivery every 3 months with an assurance visit every 6 weeks. Adults receive care delivery every 6 months with a face to face assurance visit every 8 weeks. Adults residing in NHS England commissioned beds are visited once a year; those in 'low' and 'medium' beds with a Ministry of Justice restriction and a sentence to complete, receive intensive support.

Personal health Budgets
Where possible, people with a learning disability, autism or both will be enabled to have a Personal Health Budget. Surrey has therefore commissioned a role to implement the PHB processes across the county. Surrey is in process of employing a lead for PHB's for people in transition to work in partnership with the LA to develop integrated service funds that enable person centred care.

Intensive Support Services and Forensic service under New Care Models
Aim to enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services. Every local health system will be expected to use some of this growing community health services investment to have a seven-day specialist multidisciplinary service and crisis care. We will continue to work with partners to further develop specialist community teams for children and adults. Surrey has invested in the ISS and has evidenced that an intensive support approach prevents children and adults being admitted into institutional care or being sent to out of areas 52 week placement schools.

Autism NICE Guidance re QOF
General Practice will be required to established and maintain a register of all patients with a diagnosis of autism. The Quality Outcomes Framework (QOF) indicators are focussed on establishing a register of people therefore it is not underpinned by specific evidence based recommendations. It is anticipated that this register, when implemented could facilitate measurement of related aspects of care that are contained in. It is anticipated that implementation of a register of people with autism could provide a number of opportunities to improve care and outcomes including:

- measuring access to wider care services
- identifying where there is evidence of unequal access
- enabling services to make reasonable adjustments for people with autism
- providing an identifiable population to assess and measure longer term health outcomes and care process indicators

Dementia Diagnostics
The Surrey Dementia Strategy Learning Disability programmes has been fully researched and identified the need for specialist Dementia Diagnostic pathway for people with LD and specifically people with Downs Syndrome. Over the last 2 years the Surrey CCGs have worked with the Learning Disability Specialist provider Surrey and Borders NHS Foundation Trust on a CQUIN to work with primary care and develop a pathway for Dementia Baseline assessments aged 30 + and a full dementia Diagnostic and support service for people showing symptoms that may be indicative of early onset Dementia. This has received Transformation funding and is intended that this will be fully included in the contract for 2020/21.

Cancer

*By 2024 we want people in Surrey Heartlands to live healthy and fulfilling lives to reduce their risk of **cancer**. Should they be diagnosed with cancer we want people to be diagnosed as early as possible, to have prompt, high quality treatment and to feel fully supported throughout their journey to ensure the best chance of survival and recovery, whilst maintaining a good quality of life.*

Across Surrey Heartlands, we have some positive cancer patient outcomes with 75.6% (2016) of patients surviving one year. **We aim to improve one year survival rates to 80%.** Surrey Heartlands also has high reported patient experience through the National Cancer Patient Experience Survey (2018) with an average patient rating of care of 8.9 out of 10. However, there remain areas that need to be improved to ensure equity of outcomes for all patients. We will continue to work in partnership with the Surrey and Sussex Cancer Alliance (SSCA) to deliver ambitious transformation plans to drive improvement of patient outcomes and experience. Further detail of cancer plans over the next 5 and 10 years can be found in the SSCA response to the Long Term Plan (appendix 11).

Surrey Heartlands will work to identify the communities and areas with the highest prevalence of cancer and will target our interventions to these areas so as to reduce the health inequalities this creates. This will include a review with Public Health of the key risk factors for cancer and support prevention work to address these inequalities. We will work with our PCNs to look at their local populations and develop targeted approaches to seek to communicate the prevention of cancer encouraging citizens to lead healthier lifestyles. The impact of alcohol and obesity on cancer rates is an issue in Surrey and this will be an area of particular focus as will supporting further smoking cessation programmes for the most deprived parts of the ICS as smoking rates are much higher among the more deprived communities, having a significant impact on increasing health inequalities by reducing life expectancy in these groups.

Our performance against national waiting time standards has been variable. We have achieved the 31 day standard for first treatment (97.3%) and 2 week standard (93.1%) but there continues to be breaches within these measures. The 62 day standard continues to be challenging with people waiting longer than expected however, it is an improving position with the target being met from the middle of 2019.

Surrey Heartlands is committed to streamlining pathways and investing cancer transformation funding in additional capacity to meet the new 28 Days Faster Diagnosis Standard and ensure patients that enter a cancer pathway receive a cancer diagnosis or the all clear at the earliest stage and maximise potential for curative treatment for those with cancer. Providers are collecting the data in shadow form with it becoming a constitutional standard from April 2020. NHS England/Improvement has yet to confirm the target but it is not expected to be less than 85%.

Our plan for the next 5 years builds on our successes to date and the strong collaboration across our local cancer system, working with Integrated Care Partnerships (ICPs) including providers, district and boroughs and county council as well as the community, voluntary and faith sector to deliver the national ambitions outlined in the NHS Long Term Plan.

Screening and Prevention

The Surrey Heartlands performance for breast cancer screening is below the standard of 80% at 70% (2017/18). **Cervical cancer screening is below the standard of 80% at 72% (2017/18); we want to increase this to 77.7% over the next 10 years**. **Bowel cancer screening is below the standard of 60% at 58% (2017/18); we want to improve this by 7% by 2024.**

We will continue to improve screening uptake for bowel, breast and cervical cancers particularly focusing on ensuring equity of coverage and uptake across the four place based ICPs. This will be done by piloting support workers working with primary care and the Cancer Research UK Surrey Facilitator in the North West Surrey ICP and PCNs, which have the lowest screening uptake, to support patient knowledge of the importance of screening tests.

We will also work with the local community, providers and Public Health England to address health inequalities in screening and vaccination programmes through the identification of variation and of under-represented groups, using Health Equity Audits and specific targeted interventions for key groups and for geographical areas where there are identified inequalities. This will allow us to understand the barriers to screening and make it as easy as possible for people to access screening tests. We will work with Public Health England and each ICP to up skill staff and imaginatively support citizen engagement on the connection between healthy living and increasing activity and the prevention of serious life threatening illnesses like cancer, as well as helping citizens make informed choices to encourage healthy behaviours especially in areas with higher deprivation.

Plans to increase uptake will be supported by multi-layered and multi-channel communications strategy operating at regional, system, ICP, PCN, and practice level. Messaging must be evidence-based and use behavioural insights to maximise the benefits. GP and NHS endorsements remain powerful evidence-based interventions to increase uptake. Proactive call/recall, GP endorsed invitation letters and reminders, opportunistic conversations prompted by system flag reminders, coupled with practice-level campaigns form the building blocks of local campaigns. NHS England communications team will work with Public Health England communications teams to lead this work, advised by the PHCTs/SITs.

Local Screening and Immunisation Leads are able to offer direct support to systems on implementation. NHS England will lead the development of local public communications campaigns aimed at increasing uptake in the local population and targeted campaigns can reach under-served populations and target inequalities.

Sir Mike Richards has recently published his review of the current cancer screening programmes, which was extended to include adult non-cancer screening programmes, as commissioned by NHS England. We will work closely with NHS England regional teams as the recommendations from this report around commissioning, management and governance of screening programmes are implemented.

Bowel Screening
Plans to implement FIT120 in the national bowel screening programme are underway and FIT testing commenced roll out in Surrey Heartlands in July 2019. In partnership with the SSCA, Surrey Heartlands will work to support providers with capacity planning for the increases in activity expected from the increased uptake and positivity of the new test. NHS England has committed to extending the age cohort for bowel screening by reducing the starting age from 60 to 50. Once the timing of this change has been agreed, the central team will provide activity modelling for the increases in activity and we will work with providers to implement the age extension. Systems are asked to factor the additional endoscopy, CT radiology and histopathology into their capacity and workforce planning.

HPV Primary Screening
The national procurement process for HPV primary screening is complete and plans are in place for the mobilisation of the new laboratory serving the population of the South East region. Maintaining the existing cervical screening programme during the mobilisation is a priority and work to manage backlogs is underway. The introduction of HPV as a primary screening process is expected to result in additional colposcopy activity needing to be commissioned by CCGs. Initial activity modelling has been made available; the SSCA will work with Surrey Heartlands CCGs and providers to support systems to deliver the additional activity.

Earlier & Faster Diagnosis
We will continue to drive for earlier and faster diagnosis of cancer, including diagnosing more cancers earlier to ensure better outcomes for patients and improve survival rates. Providers are working to streamline pathways and direct patients straight to test where appropriate to support this and for achieving the new 28 Day Faster Diagnosis Standard to ensure all patients on a cancer pathway find out whether they have cancer or not as quickly as possible.

NWS has experienced poor waiting times and has established a ‘Non-Specific but Serious Symptoms Clinic’ at Ashford and St Peter’s Hospital in August 2019 to pilot a different approach to support earlier diagnosis. We will share the learning across Surrey Heartlands, and the wider Cancer Alliance footprint, to feed into the developing Rapid Diagnostic Centres/Services to speed up diagnosis for people with vague but potential cancer symptoms working through new networks providing additional capacity. We will also work with our emerging PCNs to understand and implement the requirements of the DES specification for supporting early cancer diagnosis with GPs in their local neighbourhoods. We will seek to reduce the number of patients first diagnosed in emergency departments. We will ensure that new IT systems are joined up and able to easily communicate with each other.

For people diagnosed with cancer, the 28 day faster diagnosis standard will mean they can begin their treatment earlier or put people’s minds at rest more quickly at a very stressful time. Triage is the opportunity to ensure only those appropriate go straight to test, for those where it's not suitable they will be able to have a face-to-face appointment where necessary. Surrey Heartlands providers are already collecting 28 day data for all patients from April 2019, with full monitoring against the standard beginning in April 2020.

Providers have already started work to support specialties with delivering the standard including implementing new timed diagnostic pathways for specific cancers including lung, colorectal and prostate. This includes using transformation funding to increase the CNS workforce to support with triage of the referral when it's received by secondary care and directing straight to test where appropriate and to support the patient through the pathway. SSCA is supporting providers with implementing the new timed pathway for OG and will take learning from the previous implementations outlined above to agree the best model.

Using 2019/20 transformation funding Surrey Heartlands will employ a system wide team utilising the outcomes of the SSCA’s diagnostic and capacity modelling project, working collaboratively with the

SSCA and linking across organisations within NWS ICP, including digital teams, to drive further roll out of timed pathways to all specialties to support with meeting the 28 day standard. This project will start in NWS but the learning will be spread across Surrey Heartlands through an evaluation process to support other ICPs with implementation.

There is a national ambition for all stage I & II diagnoses to be at 75% by 2028. Currently, approximately 56% of cancer patients are diagnosed at stage I & II in Surrey Heartlands. However, there is substantial variation across the area with Surrey Downs at 62% and North West Surrey at 51%. Surrey Heartlands as a whole will aim to increase stage I and II diagnoses by 19% by 2028. Not catching cancers early can result in more diagnoses being received via emergency admissions and attendances at A&E, which is associated with poorer survival outcomes and increases stress, anxiety and inconvenience for patients. To meet this target by 2028 there will need to be an increase in uptake of screening, faster and earlier diagnosis through timed pathways and the faster diagnosis standard, introduction of Rapid Diagnostic Services and an increase of GP referrals to obtain the desired 3% conversion rate outlined through NG12 (figure 43).

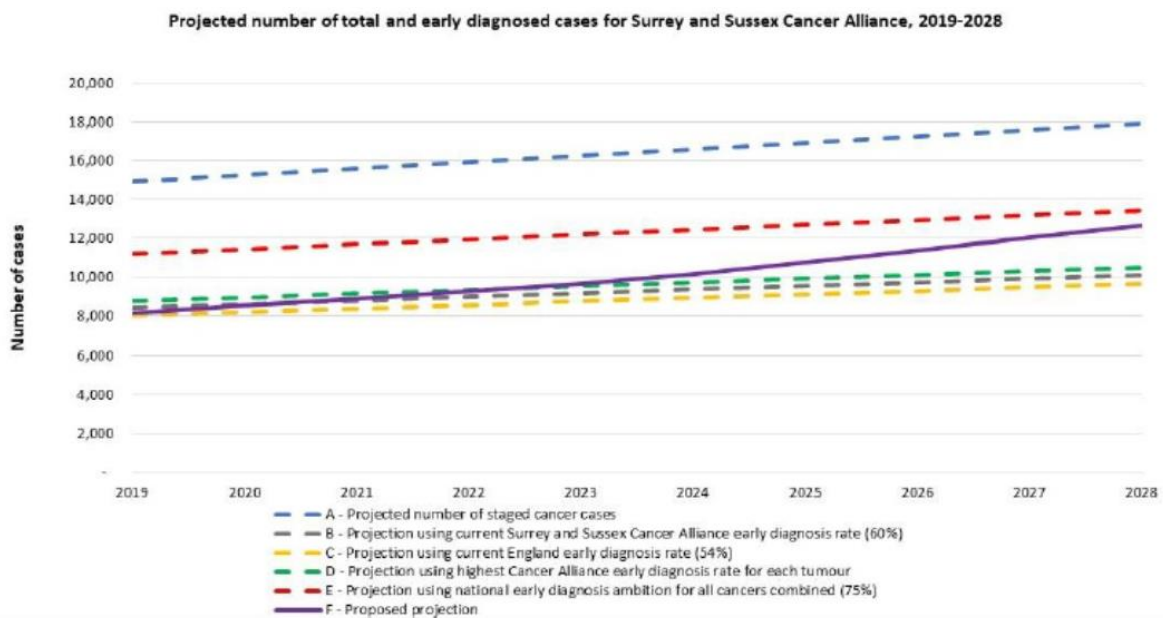


Figure 43

At Surrey Heartlands ICS level, our plans for the proportional of cancers diagnosed at Stages 1 and 2 are fully aligned with National Ambition (8% increase), hence a **compliant** position by the end of 2023/24In order to achieve all of this there will be a significantly greater demand placed on diagnostic services, in addition to patients receiving timely and effective treatment when they are diagnosed with cancer. This will enable a greater use of the existing diagnostic and pathology networks (BSPS) to support improved cancer diagnostics across Surrey Heartlands.

Rapid Diagnostic Centres and Services

The SSCA's approach to Rapid Diagnostics is aiming for a service provision rather than a fixed centre, which reflects the population, geography and demographic need. They are exploring virtual and face to face models and may implement a variety of operational solutions in different localities to support the local need and resources.

In August 2019 ASPH launched a Non-Specific but Serious Symptoms Clinic for NWS CCG patients due to them being an outlier for early diagnosis and patient experience. The aim is to roll out to further patients within Surrey Heartlands by 2020. ASPH are also working closely with the SSCA to roll out to

a specific cancer tumour group by 2020/21. An evaluation on the service will be completed to take the learning prior to further roll out.

RS and SASH have engaged in initial discussions with QVH and the SSCA for the potential to set up a virtual RDS across the sites from 2020/21. These discussions are in the early stages and will need further work up, and alignment with ASPH throughout the rest of 2019/20. We need to consider travel times/access requirements for patients and staff. The SSCA is aiming to deliver at least one Rapid Diagnostic Service in 2019/20 with a phased roll out plan created for delivery of entire population up to 2024, including additional cohorts of patients for currently challenged pathways.

Lung Health Checks
Surrey Heartlands is not part of the initial wave of the nationally funded programme for Lung Health Checks. We expect to receive funding when the programme is extended from 2022. Prior to this, consideration will be given to understand the areas of deprivation within Surrey Heartlands as well as working with Public Health England regarding reducing smoking, which is the biggest preventative cause of cancer.

Treatment
We will continue to improve our treatments and services for people with cancer, particularly specialist radiotherapy services and cancer care for children and young people. We will seek to continue to provide the existing high quality specialist complex cancer surgery provision within Surrey Heartlands to limit disruptive travel and ensure that care is provided closer to home wherever possible. We will monitor patient outcomes in all treatment areas to identify and address more challenged areas and reduce unwarranted variation. We will explore access to local gene therapies and the increasing role of personalised medicine delivery. We will underpin all the excellent work on cancer locally with robust research and development continuing to provide access to leading edge treatments as they emerge.

Genomics
The SSCA will work with the Genomics Hub (GSST for our region) to facilitate the handover of cancer molecular testing for certain tumours (e.g. lung, breast, colorectal and melanoma) to either be delivered by the hub, or more locally with quality assurance from the hub laboratory. Panel testing (whole genome) will also be available for certain tumour types; in particular paediatrics, sarcomas, haematological cancers, and CNS tumours.

First steps will be to bring together the relevant clinical leads for the above tumour sites, and the local pathology services (BSPS, Viapath and Frontier) as well as cancer genetics clinical teams. This is planned for 2019 and further updates and project progress will be reported via the SSCA Delivery Board.

Enhanced Supportive Care
Enhanced Supportive Care (ESC) is a new national programme, aiming to fully support the physical and psychological needs of patients with cancer who are receiving treatment at the Royal Surrey County Hospital. Initially developed by the Christie NHS Foundation Trust, Manchester, ESC is offered alongside Oncology treatment. The Royal Surrey is receiving funding from NHS England for two years to support the service. Once fully established, the service will be offered to all patients with cancer, irrespective of tumour origin. A dedicated ESC team will consist of specialist consultants, doctors, nurses and project management staff. Depending on individual patient needs, outpatient consultations will be offered face-to-face at St Luke's Cancer Centre, or via telephone or video consultations. The use of digital health will promote accessibility to the ESC service, and facilitate remote symptom monitoring via a secure digital health platform. Additionally, the ESC team will be available to review patients in the Emergency Department and Emergency Assessment Unit (Monday to Friday, 9am to 5pm). The learning from this will be shared across all cancer units in SH ICS.

In summary **improving cancer outcomes** will be achieved through effective, aligned and collaborative working with Cancer Centres and SSCA to:

- Ensure equal access to radiotherapy provision and compliance with national policy by maximising the use of current provision and upgrading current stock through the commissioning of radiotherapy networks
- Deliver the revised Head and Neck Cancer specification working with Specialist Commissioning as they review the providers in SE Region. We will align this with our own SH ICS work on Fragile Services as required
- Manage demand for PET CT through the additional resource procured through phase 2 of the national programme
- Promote the expansion of Enhanced Supportive Care, and take a leadership role in sharing learning across the South East, to enable patient choice and informed decision-making, pump-priming investment in priority cancer providers to achieve this
- Establish Teenage & Young Adult cancer networks within the South East and potentially participate in the development of a third network covering integrated pathways with London

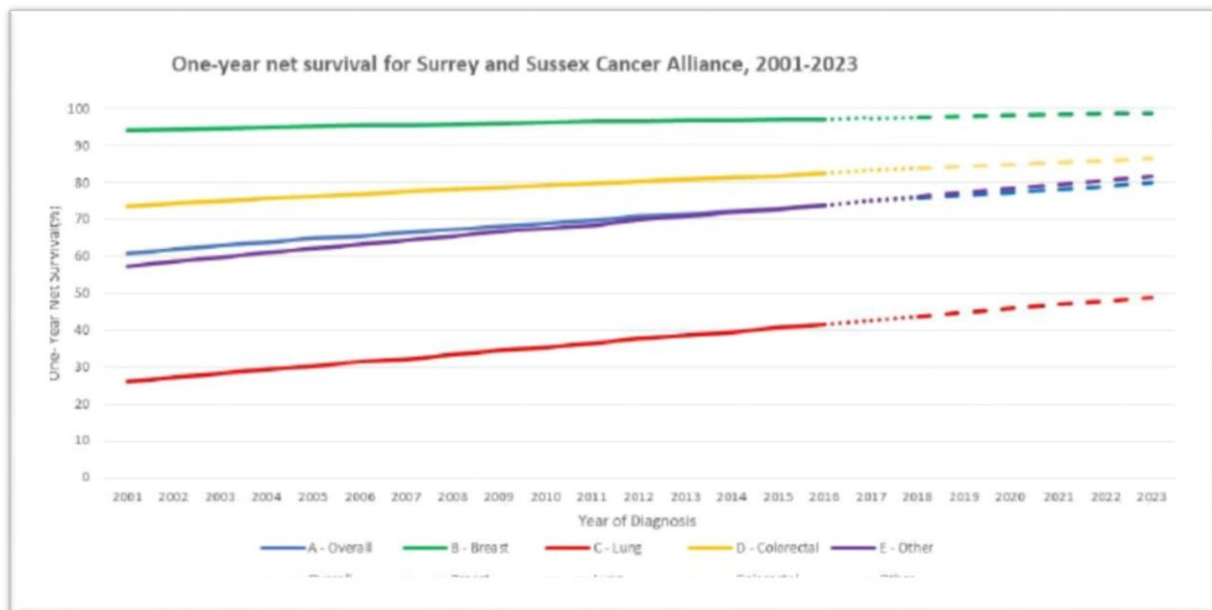


Figure 44

Personalised Care
We will continue to implement personalised care services and support for people living with and beyond cancer, and their carers including a needs assessment, a care plan and numerous methods for accessing health and wellbeing support and information including a focus on improving the quality of Cancer Care Reviews through PCNs. By 2021, all patients should be offered a Holistic Needs Assessment (HNA) and Care Plan and access to Health and Wellbeing Information and Support. We will also continue to roll out personalised, supported self-management follow up pathways for patients when their treatment ends in order to reduce the follow up burden, starting with breast, prostate and colorectal cancers. We will work with the SSCA to understand and implement the Quality of Life Metric when it begins national roll out.

Across Surrey Heartlands, there is significant variation in the percentage of patients, who receive HNAs, Care Plans, Health and Wellbeing Information and Support, and Treatment Summaries. That does not mean that these interventions do not happen, but there has been notable difference in

approach to delivery and methods of data collection. Until now, there has been no formal statistic relating to Living with and Beyond Cancer (LWBC) transformation and Personalised Care projects. HNA activity recorded in Cancer Outcome and Services Data (COSD) is therefore being used as a proxy measure for roll out of Personalised Care and Support Planning. In order to address inequalities, PCNs with the lowest take up of Cancer Care Reviews and/or highest areas of deprivation/highest incidence of cancer will be approached initially to ensure maximum benefit from the project.

The SSCA recognised the value in understanding the digital landscape in order to facilitate the implementation of interventions such as HNAs, Treatment Summaries, Remote Monitoring Systems and Personal Health Records. In 2018, they recruited a Digital Project Manager to lead a base lining exercise across the region and to strengthen relationships with digital and IT colleagues at provider and STP/ICS level. The culmination of this work is being used to inform recommendations for future Digital Innovations therefore implementation of the Macmillan eHNA Tool, Somerset Cancer Registry developments, recommendations for a Remote Monitoring Solution, and the Requirements Specification for a Personal Health Record (PHR) to support patients living with and beyond cancer. Following on from a baseline study in 2018/19 and an extensive engagement programme, what the SSCA heard from providers was that they didn't have the people resource to take forward personalised care interventions. In 2018/19 the SSCA funded dedicated personalised care project managers to be based in all trusts to drive roll out of the personalised care interventions and breast supported self-management pathway.

Within G&W CCG Macmillan has funded the Integrated Cancer Care Team which is integrated with adult community health services to support those LWBC. The service will drive forward full implementation of the Cancer Recovery Package, and development of services to support patients that are on supported self-management follow up pathways. The specialists in the Team will provide cancer expertise to multidisciplinary discussion, be available to support community teams in managing those LWBC and provide training and education. The service began seeing patients in August 2019 and an evaluation has been funded to understand the learning for potential roll out across the rest of Surrey Heartlands.

Macmillan has funded a cancer pathway interface project, hosted by G&W CCG, to enhance the relationship across primary, secondary and community care. Through this project and other Macmillan projects across the Alliance footprint, Primary Care Education Facilitators will deliver a package of training to practice nurses, practice staff and community nurses and AHPs to support the spread of cancer expertise in primary and community care.

Surrey Heartlands intends to use a portion of the cancer transformation funding to explore personalised care with pilot PCNs in each ICP footprint to take the learning from the Devon model and run collaborative sessions facilitated by Macmillan GPs, to look at the issues surrounding LWBC and the role of primary care in this, to use the Macmillan GP Quality Toolkit module on Cancer Care Reviews to identify areas for improvement and to agree and implement an action plan at practice and PCN level.

Follow-up pathways

The SSCA has developed a set of centralised guidance to support the implementation of personalised care interventions and supported self-management follow-up pathways including for implementing a breast, colorectal and prostate supported self-management follow-up pathway. Providers are already in the process of implementing pathways for breast and have begun discussions for the best models for colorectal and prostate. This work is being driven by the project managers funded by the SSCA in 2018/19.

Surrey Heartlands is in the final stages of procurement of a PHR solution to support citizens with multiple co-morbidities across Surrey. Surrey Heartlands is working in collaboration with the SSCA in the development of this solution to support cancer patients living with and beyond cancer. There is a

shared ambition to have an initial controlled Personal Health Record pilot for breast cancer patients on supported self-management pathways by the end of 2019/20. Personalised care means any care should be holistic and individual to the patient. It is key that only appropriate patients with the confidence and ability to manage their health are moved onto a supported self-management pathway.

This stratified follow-up approach will be established in all trusts for breast cancer in 2019, for prostate and colorectal cancers in 2020 and for other cancers where clinically appropriate by 2023.

Workforce

We will align closely with the SSCA workforce plan to continue to support, build and develop our staff and ensure our cancer workforce is fit to provide all patients, including those with secondary cancers, with the right expertise and support. We will address staff shortages to ensure all patients have access to a Clinical Nurse Specialist or other support worker and will support nurse led service provision. We will work with Berkshire and Surrey Pathology Services, our local pathology provider, to introduce more digital tools and mitigate some of the serious shortages in this important diagnosis pathway (see chapter 7). We will work with our providers and the SSCA to understand other staff shortages in key areas and how the Rapid Diagnostic Centres/Services and networks may help to support with this. We will transform the role of the MDTs so that these are as effective as possible and reduce the time spent by scarce clinical resources. We will work with other Surrey Heartlands outpatient transformation programmes to see a reduction in follow up appointments using a risk stratified approach as clinically appropriate thus releasing time for more first appointments.

Sufficient workforce capacity on the programme pathway is fundamental to safe and effective delivery of the programmes. Existing workforce challenges in breast radiology and radiography, endoscopy, histopathology and colposcopy all need to be addressed through system workforce planning. Any increases in uptake need to be matched by increased capacity in the receiving programme in order that all programme standards along the pathway can be maintained.

Closing the workforce gap will involve taking advantage of advancements in technology which will require workforce to adapt and evolve to ensure we maximise performance improvement with the finite resources available.

Cardiovascular

By March 2024, we will have improved the prevention early detection and treatment of cardiovascular disease to meet our ambition that ***over 5000 people with hypertension and over 1500 with possible AF will be identified****. We will increase the diagnosis of* **Familial Hypercholesterolemia to 25%** *and* ***increase capability and knowledge of healthcare professionals*** *for lifestyle advice.*

Cardiovascular disease (CVD) is a leading cause of death in the UK with 1 in 4 deaths in England caused by CVD. In Surrey approximately 20% of deaths in 2017 were caused by either ischemic heart disease or stroke. The NHS long term plan states that CVD "is the biggest single area where the NHS can save lives over the next 10 years"[31]. The NHS and Public Health England (PHE) aim to save 150,000 heart attacks, strokes and new cases of dementia over the next 10 years. One of the main objectives is to focus on increasing the detection and management of the 'ABC' (atrial fibrillation, blood pressure & cholesterol) of cardiovascular disease. The key priority areas for our local populations is hypertension and AF detection. Taking blood pressure as a key risk factor, people from the most deprived areas are 30% more likely than the least-deprived to have high blood pressure, and the condition disproportionately affects some ethnic groups including black Africans and Caribbean's.

Across Surrey Heartlands we have created a programme of CVD which aligns prevention, detection and treatment of Cardiovascular Disease including working to increase detection of high blood pressure, Atrial Fibrillation, cardiac high risk conditions and high cholesterol. The models include:

- AF/ Hypertension programmes in partnerships with High Street Pharmacists, Voluntary Sector and the local NHS and County Council workforces across Surrey Heartlands. Since launching BP+ on 1st April 2019 over 2000 BP+ checks have been delivered across Surrey in workplaces, community pharmacies, outreach locations, and places of worship. Having delivered over 2000 BP+ checks the project has identified >336 patients with blood pressure greater than 140/90 mmHg (approx. 17%). This is only slightly lower than the estimated prevalence for the total population (approx. 22%), suggesting that BP+ was able to identify patients with hypertension at an acceptable rate. The project demonstrated that by working in partnership with a number of organisations (CPSS, SCC, CCG's & DoG) BP+ could be launched in a variety of ways that increased the likelihood of patients participating in the service. Working in partnership also enabled us to share information, ideas and IT Systems for the benefit of the project.
- Cardiac Rehabilitation programmes are working across the ICS to increase update and create new models of partnership within the ICP's. The programme is aligning with new partnerships such as FA Surrey for walking football rehabilitation programmes and early detection of hypertension. Technology and Group clinic approaches are being utilized to create communities of patient led service provision.
- Primary Care Networks have created new models of cardiology pathways and Referral Support Services have GPSi's in place that review referrals, increase access to echo cardiology, 24 hour ECG and stable chest pain pathways.
- Early community response models are working in partnership with SECAmb and community providers to ensure First Responders and defibrillator access at point of need.
- Surrey Heartlands as an ICS is working closely with colleagues across the System to shape a collective response to identifying people at risk of developing CVD. We are strongly committed to: Increase opportunistic testing in primary care through using wider staff (nurses, pharmacy, GPs etc.) and integrating testing into the management of long term conditions; improve a more targeted delivery of the NHS Health Check programme; target high-risk and deprived groups, particularly through general practice records audit and outreach testing.
- Links to preventive programmes are in place to reduce risk factors such as alcohol, obesity, smoking and lifestyle management. These programmes are forming new partnerships across Industry and the local communities and voluntary sector.
- We are working very closely with SECAmb and the BHF and together have plans to actively contribute to the development of a national defibrillator database. It will be held by the ambulance service so their call handlers will see it on their Systems and direct whoever has made the call to them. The BHF is working with the local ambulance service on making sure their existing databases are added and a local marketing campaign to get all of them registered.

Current CVD Prevalence for Surrey Heartlands

Indicator Name	Time Period	Value	Rate
Stroke: QOF prevalence (all ages)	2017/18	1.61	% of practice register
Hypertension: QOF prevalence (all ages)	2017/18	13.07	% of practice register
Heart failure w LVD: QOF prevalence (all ages)	2017/18	0.16	% of practice register
CVD-PP: QOF prevalence (30-74)	2017/18	1.13	% of practice register
Coronary heart disease mortality rates, under 75 years	2015 - 17	26.12	per 100,000
Stroke mortality rates, under 75 years (age standardised)	2015 - 17	10.27	per 100,000

The ICP models

Within our local ICP communities we have a variance which requires local solutions:

- The different cardiovascular diseases are the most common long term conditions in Guildford and Waverley CCG. Around 12.5% of the population have been diagnosed with hypertension, 2.5% with Coronary Heart Disease, 2.0% with Atrial Fibrillation, 1.4% with Stroke or Transient Ischaemic Attack, 0.5% with heart failure and 0.4% with Peripheral Arterial Disease. About 4.5% of the population of Guildford and Waverley CCG have been diagnosed with diabetes and 3.3% with chronic kidney disease. The diagnosis gap between those diagnosed and the expected prevalence of specific diseases varies: over 50% of those with hypertension, chronic kidney disease or heart failure are potentially undiagnosed. Over one third of those with diabetes may be undiagnosed. Individual practices vary substantially in the level of diagnosis gap for different conditions.
- Within North West Surrey CCG, the proportion of undiagnosed people is estimated at 30% for atrial fibrillation, 55% for heart failure, and 50% for hypertension. The recorded prevalence for these conditions is 1.7%, 0.5%, and 12.6% respectively.
- The recorded prevalence for heart failure in Surrey Downs is 0.5%. It is estimated that 58% of people with heart failure remain undiagnosed. The recorded prevalence for hypertension in Surrey Downs is 13.8%. It is estimated that 47% of people with hypertension remain undiagnosed. The recorded prevalence for atrial fibrillation, a risk factor for stroke, is 1.9%. It is estimated that 33% of people with atrial fibrillation remain undiagnosed. The recorded prevalence for chronic obstructive pulmonary disease (COPD) in Surrey Downs is 1.2%. It is estimated that 37% of people with COPD remain undiagnosed.
- The recorded prevalence of Smoking in East Surrey is 14.2%. Hypertension prevalence is 12.6%. Blood pressure <= 150/90 for people with hypertension. Patients who have a record of Blood pressure aged 45+ over the past five years is 88.5%.

These key variance will be the focus as we create local community and System solutions. This work will align with the local models of Population Health management and optimize risk stratification and impact on the wider determinants of health.

Our Future Ambitions

The following sets out the national care ambitions for cardiovascular disease.

Atrial fibrillation- achieved through new models of partnership and detection programmes.	85% of the expected number of people with AF to be detected by 2029
	90% of people known to have high risk AF to be adequately anticoagulated by 2029.
High blood pressure- risk stratified target approach within the local PCN's and ICP's.	80% of the expected number of people with high blood pressure to be diagnosed by 2029
	80% of those diagnosed with high blood pressure to be treated to target as per NICE guidelines (below 140/90 mmHg for those under 80 years; below 150/90 mmHg for those aged 80 & over).
High cholesterol- FH programme across Surrey Heartlands, CVD assessments in PCN's and risk monitoring via Medicine Management.	75% of people aged 40-74 years to have a formal validated CVD risk assessment and cholesterol reading recorded on a primary care System in the last five years by 2029

High cholesterol- FH programme across Surrey Heartlands, CVD assessments in PCN's and risk monitoring via Medicine Management.	45% of people aged 40-74 identified as having a 20% or greater 10-year CVD risk in primary care to be treated with statins by 2029
	25% of people with familial hypercholesterolemia (FH) are diagnosed and treated optimally according to NICE FH guidance by 2024.

To achieve our local ambition for cardiovascular, Surrey Heartlands will:

- With new models and ambition reach its target of 16,000 BP+ checks by the end of March 2021 to identify 2,720 patients with hypertension and 640 with possible AF (based on current detection rates of 17% for hypertension and 0.4% for AF). Assuming all of these patients received appropriate treatment it is estimated that we would save 66 lives if the BP+ programme were to continue until 2021. **Post 2021 and based on current estimates, over 5000 people with hypertension could potentially be identified, and over 1500 with possible AF.**
- Deliver on the NHS 10 year plan ambition to **increase the diagnosis of Familial Hypercholesterolemia to 25% from a current diagnosis baseline of 7%. Across Surrey Heartlands it is estimated that 3,348 individuals may have undiagnosed FH.**
- Explore the delivery of digital health checks and improve models of detection and self-management.
- Create local System responses that tackle the unwarranted variation across the System and impact on CVD. With focus on the National requirements and improvements in quality.
- Develop the capability of healthcare professionals through access to training on risk communication, motivational interviewing, brief advice and Making Every Contact Count (MECC), enabling delivery of brief interventions for lifestyle advice in line with NICE guidance.
- Promote healthcare professionals engagement with and amplification of public health campaigns such as One You and Change4Life.
- Optimise opportunities for embedding personalised care throughout CVD pathways through shared decision making, personalised care and support planning, supported self-management and social prescribing, including facilitating access to community-centred, asset-based support.

Stroke care

By March 2024, stroke services in Surrey Heartlands will have been developed to improve services around Integrated Stroke Delivery Networks (ISDNs), ensuring that thrombectomy and thrombolysis will be received by those that need it and continue to provide early supported discharge.

The development of a Stroke integrated stroke delivery networks (ISDN) will help to ensure that the pathways and national expectations are achieved in the coming years with improved access to direct stroke unit beds from A&E. It is proposed that the ISDN will align with our established Trauma Centres to allow rapid access treatment models and improve patient flow and is being planned in partnership with the SE Clinical Senate and London & Thames Valley Senate, with the final **local footprint agreed and governance in place by 2020**.

We plan to meet the national (England) target for the proportion of patient admitted directly to a stroke unit in 4 hours, **each year with incremental improvement up to 80% by 2023/24** (figure 45).

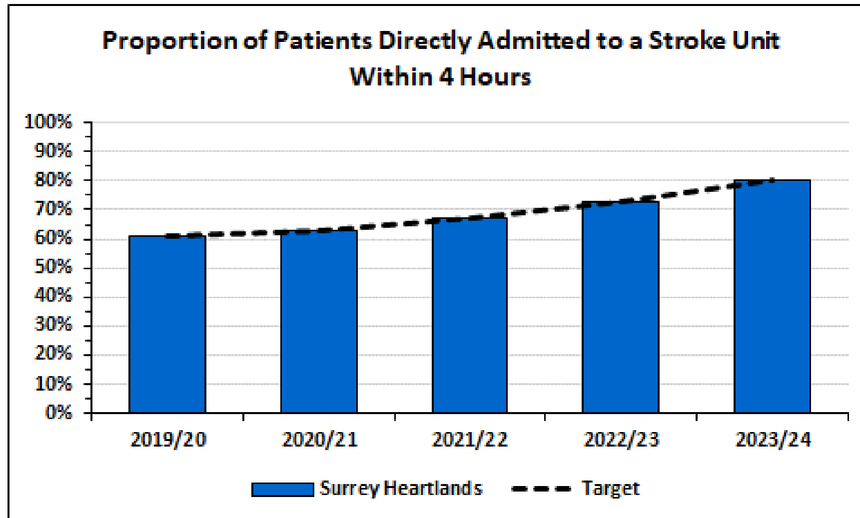


Figure 45

The 6-month follow up is part of the current specification and has been included in the Surrey Stroke review as a key area for delivery improvement. It has identified that further work and investment to **improve stroke community provision** and **early stroke discharge** may be required. Improvement plans are being developed during 2019 which include investigating the data capture of activities relating the 6 month stroke assessments, due to the recognised disparity between service provision and performance reporting. We aim to **meet the national target** by 2023/24, when at least 60% of applicable patients will be assessed at 6 months. Figure 46 shows the trajectory to this point.

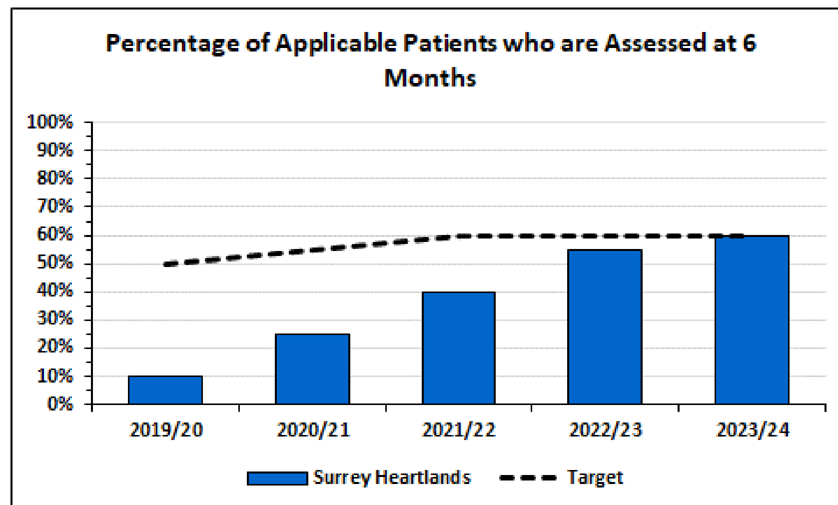


Figure 46

The ISDN will model activity and travel flows to inform the future configuration of Hyper Acute Stroke Units (HASU) across the ISDN geography especially as stroke volumes are projected to reduce over time recognising the work of CVD prevention. Proposals around stroke service infrastructure requirements will be reviewed following the completion of a modelling led by the Stroke Association.

The ISDN will ensure that the commitment to deliver the national and local stroke service specification and standards across whole patient pathway are in place for all local people. There will be an ongoing focus on a high quality stroke clinical model to deliver SSNAP A audit across all the ISDN sites. The good access to thrombectomy service at St George's University Hospitals Foundation NHS Trust will be maintained with clear and robust pathways in place for rapid treatment.

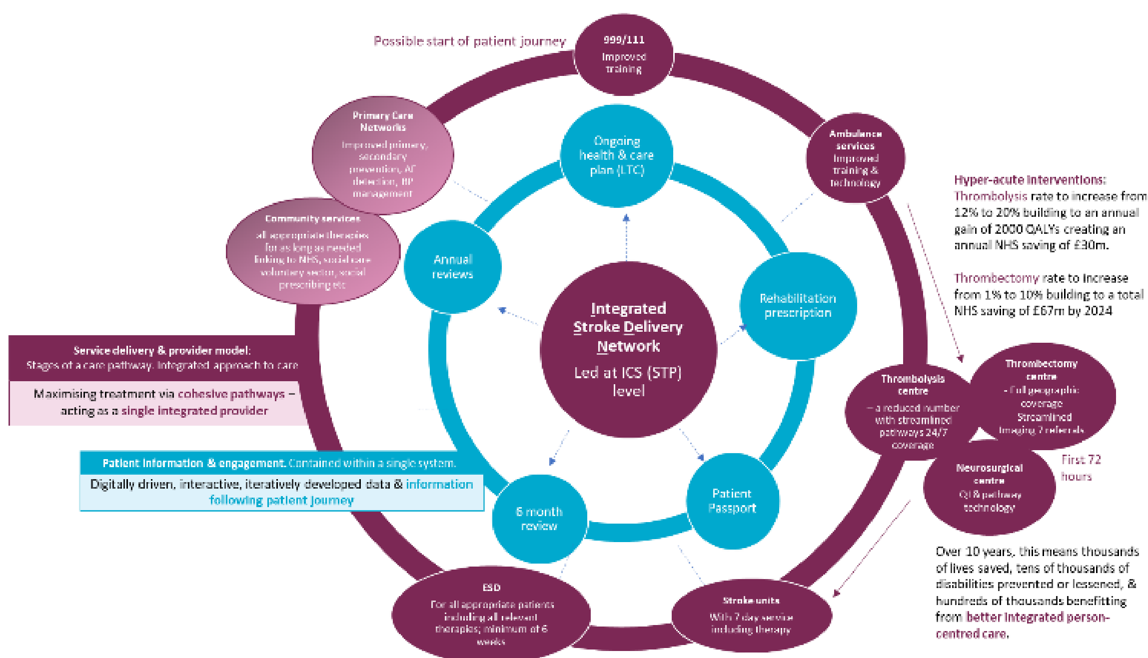
The new ISDN will deliver and monitor all improvement components of the stroke plan across whole the patient pathway from prevention to life after stroke. There will be a focus on workforce planning and optimisation and competency-based training will be put in place.

Continuing the excellent work already underway in SH ICS to improve detection of Atrial Fibrillation (AF) and then optimising treatment to reduce the number of AF related strokes. Also linking to the successful detection of high blood pressure programme which seeks to prevent future strokes.

Extended Stroke Discharge (ESD) is in place across Surrey Heartlands and is provided by community partners. Community partners are part of the ICPs across Surrey Heartlands ICS driving a strong integrated service outside hospital. ESD is often linked to the wider community integration programmes of each place. Following the Stroke Review in Surrey in 2016/17, ESD became a commissioned service across Surrey Heartlands. We will deliver ESD and 6-month reviews in all areas to reduce unwarranted variation.

All of these initiatives will deliver reductions in strokes and improved outcomes for those who have a stroke. We will ensure that patients and carers and voluntary sector organisations are integrally involved in shaping services building on our existing co-production process with citizens. We will identify plans across the 6 key areas for stroke services; prevention, acute pathways, rehabilitation, workforce transformation, digitally enabled transformation and costs of services.

Model of ISDN – Proposed functions



Diabetes

*By March 2024 there will be consistent **diabetes care** across the System with reduced variation of care across GP practices and CCGs.*

Our aim over the next 5 years is to ensure pathways will be streamlined with organisations working together to care for people with diabetes in the right place at the right time. We will continue to further our **excellent progress for the percentage of people with HbA1c tested in year, by exceeding**

the national average (95.3%) and improving on our current full year[32] rate of 95.6%. We expect to continue the same approach for the **percentage of people with all 8 tests carried out in primary care; the national average (58.8%) and improving on our current full year rate of 61.3%.**

All citizens at risk of developing type 2 diabetes will be identified and offered a place on the National Diabetes Prevention Programme (NDPP). People with diagnosis will be supported to self-manage through a menu of education programmes. Digital options will be optimised in all aspects of diabetes care and education including online education programmes for citizens and professionals. We will appropriately prescribe flash glucose monitors, and **by 2021 all pregnant women with type 1 diabetes will be offered continuous glucose monitoring.**

Prevention

- Work with the prevention workstream and Diabetes UK Champions to ensure that people at risk of developing diabetes are screened, identified and engaged with early
- Fund primary care to maintain registers, ensuring people at risk of developing type 2 diabetes are monitored annually and encouraged to attend education
- Refer 2,218 people p/a to the National Diabetes Prevention Programme from 2019-2023

  The ambition is to double the number of people to the National Diabetes Prevention Programme; for Surrey Heartlands this means increasing the number from 2,215 in 2018/19 to 4,860 by 2023/24. Figure 47 shows the trajectory to this achieve this.

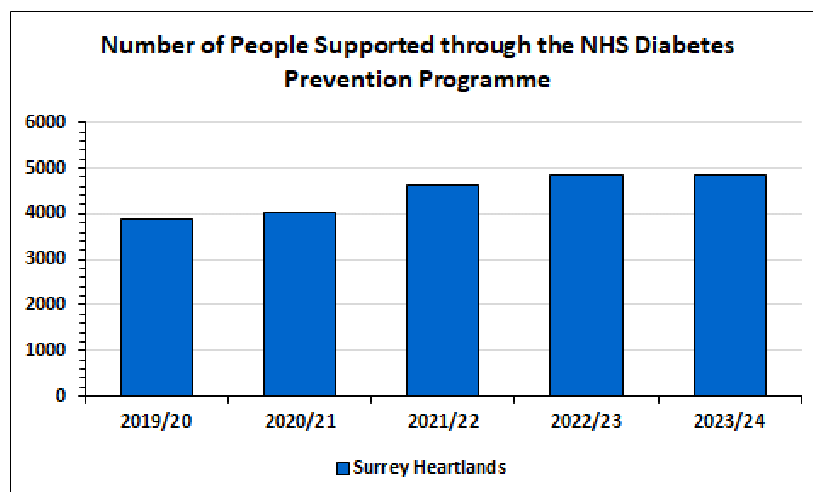


Figure 47

Consistent Diabetes Care

- Reduced variation of care reflected in the National Diabetes Audit (NDA) through:
  - Developing our workforce by offering of a programme of diabetes education and offering backfill payments to release staff in GP practices to attend
  - Designing and embedding tools in GP Systems to identify and support people with diabetes such as System searches and reports
  - Designing templates to ensure work undertaken is correctly coded and recorded
- One outcomes based service specification for primary care based on NDA objectives
  - Hold workshops across all Providers to streamline pathways

[32] 2017/18

- Reduce waste and duplication with dual way viewing of clinical notes between primary and Acute services in Guildford and Waverley and Royal Surrey County Hospital
- Ensure all Acute Trusts provide access to multidisciplinary foot care teams and Adult Inpatient Diabetes Services are accredited under the CQC led process commencing in 2021

Support self-management

- Supporting people with diabetes to self-manage by:
    - Increasing capacity at Structured Education (SE) courses for both T1 and T2
    - Offering people with type 2 diabetes options to self-refer to face to face and remote, digital education programmes
    - Incentivising practices to identify people with diabetes and offer education courses
    - Commission and provide equitable access to medical devices for type 1 diabetes in line with national guidance

Use of Technology and Digital

- Increased use of digital technology such as: virtual clinics, Flash Glucose Monitoring (freestyle libre), Continuous Glucose Monitoring (CGM) in pregnancy and understanding of Closed Loop Systems.

Respiratory disease

*The ICS is supporting the continued work to integrate **respiratory** care pathways to bring about improved early diagnosis, supported by self-management and pulmonary rehabilitation where most effective. We expect these developments will reduce the health inequality challenges in this area (see prevention) and to develop citizen's understanding, use and uptake of new medicines and devices.*

Early, accurate diagnosis & self-management

ICPs have in place integrated respiratory services (IRS) seeking to improve efficiency and effectiveness and earlier detection. The IRS is a Consultant led Community MDT service aimed at supporting patients with COPD, Asthma, Bronchiectasis and Interstitial Lung Disease by educating them to self-manage their condition. This will improve patients' quality of life so they experience fewer exacerbations, thereby preventing unnecessary respiratory admissions or re-admissions and support post hospital discharge.

Using the JSNA, a population health management based approach, with focus on local community health inequalities, is being used to targeted delivery of services via our PCNs. We will be developing how social prescribing can support citizens with self-management and preventative activities as it evolves over the next 12- 18 months.

As part of the Integrated Respiratory service in GW ICP, it is developing virtual clinics within Primary Care to enable specialist RSCH Respiratory Clinicians to educate and support GPs on appropriate referral pathways, early detection and treatment (i.e. inhaler prescribing and follow up). Service has had positive feedback from pilot GP Practice and will be rolled out to all GW GP Practices. Nurse-led Community clinics have been established which incorporates pulmonary rehabilitation (PR) in the care bundle, with referrals via the Clinical Co-ordination Centre as a single point of access. With support from the Medicine Management team, PR and IRS nurses will begin targeted education and awareness sessions with specific GP Practices (i.e. those with unmet needs) over the next 12 months.

In North West Surrey, Rightcare[33] data has been used to estimate the number of people who would benefit from pulmonary rehabilitation. Population Health Management data has provided an insight into which localities have the highest number of patients with COPD. A risk stratification tool will be mobilised within primary care which will detect and support diagnose of COPD earlier.

Surrey Downs ICP are currently developing a new Locally Commissioned Service (LCS) with Primary Care colleagues to support the creation of diagnostic hubs in PCNs. These will provide quality assured (ARTP equivalent standard) spirometry (performing and interpreting) to improve the accuracy of diagnosis and ensure patients are on the correct management pathway. This will increase referrals to pulmonary rehabilitation and smoking cessation services. Risk stratification methodology will be used to identify the patients most at risk.

East Surrey ICP have plans to improve the delivery of respiratory care, by focusing on respiratory care in the community. A plan has been set out to redesign respiratory pathways such that admissions from respiratory conditions can be reduced through a new pathway to manage different levels of complexity across primary care, general and specialist community services, commissioned and delivered in alignment with PCNs. The ICP is also exploring through its transformation funding an integrated respiratory pathway.

Medicines Optimisation
LCS are in place supported by a Respiratory Nurse Consultant and pharmacists with in the medicine optimisation team to support primary care HCP's optimise respiratory management. Virtual clinics, educational groups and individual support are on-going to support practice staff optimise COPD and asthma reviews. Spirometry training and a local register have been established which support correct diagnosis of patients with respiratory disease, with correct management pathways and appropriate inhalers prescribed. Inhaler device training and information to support local guidelines is on-going and work is being initiated to look at green issues with device choice.

Pharmacists in primary care networks are beginning to undertake a range of medicine reviews, including educating patients on the correct use of inhalers and contributing to multidisciplinary working. As part of this work, they can also support patients to reduce the use of short acting bronchodilator inhalers and switch to dry powder inhalers where clinically appropriate, which use significantly less fluorinated gases than traditional metered dose inhalers. Pharmacists can also support uptake of new smart inhalers, as clinically indicated.

We are currently recruiting clinical pharmacists to the PCNs across Surrey Heartlands and developing options an integrated model with acute hospitals. A pilot is being contemplated in North West Surrey in a PCN and local interested community pharmacies to support patients around their management of respiratory disease and use of inhalers to test the approach over the next 12 to 18 months.

Adult mental health services

*Our vision is a future where **people's mental health is part of, not the totality of their 'story'** and people are supported as part of an integrated System that acknowledges physical & mental health factors & recognises the pivotal importance of carers and a family approach. **People can expect that the System recognises that the social (wider) determinants of health** (embracing social prescribing & peer support approaches) are paramount and evidence based interventions are there when people need them. **People will be empowered and supported by their communities who are informed on mental wellbeing**; building sustained resilience and independently driven recovery building capacity & ensuring a preventative approach. To deliver our vision we need to utilise and embrace technology.*

[33] https://www.england.nhs.uk/rightcare/

We fully acknowledge the importance of marketing to launch us into a positive future that supports sustainable and effective mental health and wellbeing.

Our mental health transformation investment aims to provide more timely and accessible support to people with serious mental illness and those in crisis. Further work is needed to improve the range of preventative and early intervention services available to people with mental health needs and their carers/families living in Surrey Heartlands. We believe investment in this area would reduce current health inequalities, improve lifestyle choices or experience and ensure people are no more likely to use physical health services than their peers without mental health difficulties.

Our ambitions for mental health and emotional wellbeing build on the Surrey 10 year plan and the Surrey Heartlands priority to improve outcomes for people with mental health needs. We aim to improve the quality and experience of mental health support for our local population with a focus on reducing health inequalities and unwarranted variation. In Surrey it is projected that the cost of mental health will increase substantially. This is based on the Surrey JSNA predicted increases in mental health disorders, including dementia, anxiety, personality disorders, depression, psychosis, eating disorders and bipolar disorders. For example, severe depression is expected to rise by 38% for people aged over 65 (by 2026) and psychosis by has been estimated to increase by 7.2% [34].

Although at an aggregate level, Surrey mental health prevalence rates are lower than the England average, the number of conditions in the area continues to grow (as above) and we have several outliers from the national position; eating disorders (6.89 vs 6.73), post-traumatic stress disorder (3.11 vs. 3.02) and panic disorder (0.73 vs.0.65). There is variation in prevalence rates across Surrey Heartlands in terms of geography, the population impacted and level of deprivation as would be expected from known mental health risk factors. Across different population groups, school children and women during pregnancy and/or after childbirth seem to be impacted the most in Surrey compared to peers. The life expectancy of people with severe mental illness in Surrey Heartlands is on average 22 (males) or 16 (females) years less than the rest of the population. There is estimated to be a much higher number of people with mental health needs in our area than are diagnosed or receiving treatment and we have a larger population over 75 years of age with further increase over

[34] based on data from 2015 to 2020

the next 5 years of the 85+ age group. This will mean we will need to support people with greater co-morbidity of mental health and long term conditions and older people with depression.

The life expectancy of people with severe mental illness in Surrey Heartlands is on average 22 (males) and 16 (females) years below the rest of the population. There is estimated to be a much higher number of people with mental health needs in our area than are diagnosed or receiving treatment and we have a larger population over 75 years of age with further increase over the next 5 years of the 85+ age group. This will mean we will need to support people with greater co-morbidity of mental health and long term conditions and older people with depression.

In terms of the wider determinants of health, employment data shows opportunities for people with mental health needs has reduced over the last 10 years and that 50% of people who claimed Incapacity Benefit or Employment Support Allowance in Surrey did so on the basis of their mental health needs. This figure is higher than the national average. **Data from acute mental health wards in Surrey shows that only 47% of people were discharged to stable accommodation following an admission**.

No. of people directly impacted	Average healthy life years lost per person	Average life gap for men with severe mental illness	Average life gap for women with severe mental illness
105,000	1.5 – 10 years	22 years	16 years

Integrated Primary Care Networks: Surrey Heartlands is 1 of 12 sites selected to deliver a primary care network based community model for adults and older adults with Serious Mental Illness (SMI). We will start in 2019 to implement new models of integrated community care in line with our 10 year plan priority (which correlates to the LTP expectations). We aim to dissolve the boundaries between primary & secondary care, providing training to primary care and integrating the pathway of our voluntary and statutory providers. We will identify needs earlier and provide easier access to services, which will include improved and more flexible pathways for young adults (18 to 25s). People will be treated nearer to home by local services within their communities and will be supported through social prescribing, peer mentors and our Recovery College to access health and lifestyle opportunities in their neighbourhood or Borough. The new model will also bolster our NICE recommended therapy offer for people with a personality disorder and spread trauma informed training for the Surrey Heartlands workforce. We expect to see an increased number of people with SMI receiving full annual health checks and more people will have enhanced support to find and retain employment.

Increasing Access to Psychological Therapies (IAPT): Linked to the above our IAPT services will continue to improve support for people with long term conditions, older people and for those from our BAME communities as well as extend access to the general population.

In accordance with the national ambition to increase the numbers of people receiving psychological therapies, we aim that 26,102 citizens will be able to receive this by 2023/24. Figure 48 shows the incremental increase over the next 5 years to achieve this.

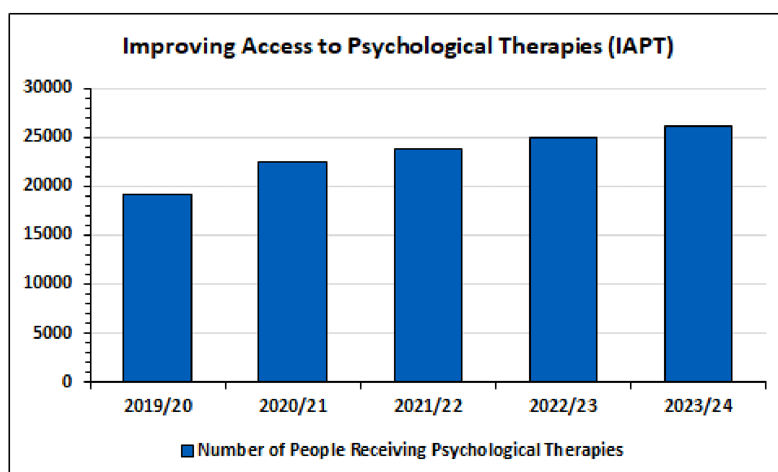


Figure 48

Employment Support: Our well established Individual Placement Support (IPS) service delivers very strong outcomes although has not had an independent assessment against the IPS fidelity model. This is taking place with the IPS Grow organisation and a development plan will be supported locally to close any gap to achieve fidelity. Our experience of employment support in Surrey will contribute to developments within the integrated primary care networks model.

Early Intervention in Psychosis (EIiP): We will be **maintaining our EIIP service ensuring that it achieves its level 3 standard in 2020.** This local transformation will lay strong foundations for a future vision that will see from 2022-2024 a re-organisation of core community mental health teams to move towards a new place based approach.

Supporting the emotional wellbeing of mothers throughout and after their pregnancy: The introduction of our community mental health perinatal service has allowed women to have access to specialist support (255 in Q1 which is over 50% of the proportionate target for Surrey Heartlands of 430). **From 2020/21 we will see an expansion of the psychological therapy on offer, assessment support to partners and development of the criteria for people who require support up to 24 months.** We will continue to ensure the work is supported by the Surrey Perinatal Network and that perinatal mental health workers will be working with maternity outreach clinics in 2022-2024.

Mental Health Crisis and Urgent Care: Our 10 year plan for crisis care is maturing and our suicide reduction plan is supported across our stakeholders. **Families and staff will be able to access timely support from a system wide suicide bereavement support service**. We have an active Crisis Concordat group that will ensure our SPA/111/999 work for mental health is integrated in line with the LTP. We will continue to enhance our out of hours acute care pathway, by enabling services (Safe Havens, Crisis line, Rapid Response and Psychiatric Liaison) to work seamlessly together. We are well prepared to improve support for people who need Urgent and Emergency support through links to the national pilot (in Frimley Health ICS) and work we are doing with our acute hospitals around joint escalation protocols. Although **our Liaison services within the acute hospitals are operating towards the CORE24 general standards, additional therapies input will enhance their impact on discharge rates** and this will be an area of priority for us going forward. We will enhance our Crisis Response Home Treatment (CRHTT) hours at evenings & weekends, expand our successful Surrey High Intensity Partnership Programme (with Surrey Police), build on the number of Peer Support Workers we have and create a trauma informed care network across all Crisis Concordat partners.

We will continue to enhance people's experience of our in-patient services by improving the therapeutic interventions and environments. This will **accelerate our work to enable recovery and reduce length of stay to within the national average of 32 days**. These areas of work are expected to support the reduction of our out of area placement (OAPs). The elimination of out of area

placements (OAPs) within this strategic period is reliant on our capital programme. Housing is also a key area that will be focussed on and will benefit from a dedicated Mental Health Discharge Team from social care coming into place with the new model of working following the s75 changes at the end of 2019.

Housing and Rough Sleeping: The number of people rough sleeping has increased significantly in Surrey in the last five years. Recent official estimates show that 69 people were sleeping rough in 2018, an increase of 245% from 2010. However there is a strong likelihood that the numbers of rough sleepers in Surrey are underestimated.

The Surrey Homeless Health Needs Audit (2016) demonstrated that a high number of single, homeless people experienced mental ill-health, with many indicating difficulty in accessing support or an assessment, and others using alcohol and other substances to support their mental health. This accords with evidence from Pubic health England that suggests that 50% of people sleeping rough have significant mental health needs with rates of psychosis estimated to be 15 times higher than average for this group of people.

Surrey Heartlands has a number of services working to address substance misuse, mental ill-health, and other areas of disadvantage. However, staff are struggling to engage this group in existing provision as people often fall between service thresholds or intentionally disengage from services, bouncing repeatedly from one crisis to another. Once in a service, individuals may struggle to benefit from support as this relies on strong relationships with staff, a flexible and bespoke approach and an understanding of their journey through services. We want to align our work in this area to ensure we meet the Mental Health needs of rough sleepers. We will work to:

- Raise awareness of rough sleeping referral pathways through primary care, substance misuse and mental health services.
- Strengthen partnership working to support effective hospital discharge and ensure individuals are fully engaged in a recovery pathway with move-on housing options (currently less than ½ the people discharged from mental health acute wards return to stable accommodation).
- Create greater understanding among staff across homelessness and other sectors about the impact of trauma and adverse childhood experiences on rough sleepers.

This work will be co-produced with people who have had lived experience to ensure that we are as effective as possible in identifying people at risk of rough sleeping.

Early diagnosis and intervention for people with Dementia: We will continue to develop dementia friendly communities (increasing beyond the exiting 3 in Surrey; Oxted, Woking and Hindhead) and work towards achieving a 6 week referral to treatment target. We will improve access to support closer to home and to specialist dementia expertise when needed. Surrey will continue to innovate in the area of dementia care by spreading our award winning digital TIHM for dementia initiative to more homes and services (within Surrey and Borders Partnership and Surrey County Council). TIHM deploys digital health technologies and artificial intelligence in the homes of people with dementia and their carers to improve quality of life outcomes. It has been shown to reduce anxiety, agitation, aggression and carer burden. We will also continue to offer ground breaking trials of new dementia and Alzheimer's' drugs.

Mental Health Transport: Work has commenced to understand the skills and competencies that might be required across ambulance crew and staff in ambulance control rooms to improve the experience and outcomes of urgent and emergency care for people in Mental Health crisis and in line with the emerging Ambulance Service Mental Health transport specification. Any changes to service specifications relating to this or opportunities to address gaps in the current provision of services for people with Mental Health needs will be picked up as part of the contract negotiations for 2020/21. SECAmb have started to strengthen provision of support for patients calling with Mental Health needs

and employ 6 WTE across in the control centre to provide clinical advice and signposting to ensure this cohort of patients receive the right response at the right time.

You can read more about our delivery plan supporting the LTP commitments in appendix 12.

Workforce, Finance & Activity
Our plan is aligned to the finance and activity schedules (utilising the NHSE MH analytics tool). There are particular challenges around workforce capacity given the pace and scale of the mental health transformation in Surrey Heartlands. We recognise workforce challenges particularly for medical, nursing and therapies staff. We are committed to:

- Grow and retain a 'wellbeing workforce' including peer support workers, social care, voluntary sector & wider community assets such as bus drivers & library staff. As part of this approach 'social influencers' will be developed to embed understanding and resilience in communities around mental health & wellbeing

- Improve workforce wellbeing and eradicate the stigma often experienced by people experiencing mental ill health in their workplace

Digital: We will have digital enabled services and will offer a range of self-management apps, digital consultations and digitally enabled models of care and digital dictation to release more clinical time. We will need support from our system partners to overcome the challenges and need investment in this area. There is a clear LTP expectation that ICS systems need to provide better data and enable digital maturity to support people with mental health needs. If we do not capitalise on the digital opportunities our work will not be sustainable and transformational. This therefore will be a key area of activity and commitment to underpin all of our work streams and will link to the wider ICS Digital Strategy.

Aligned Programmes: Our mental health transformation is based on integration, prevention and early intervention. This alignment is illustrated in figure 49. There are clear links to other programmes e.g. primary care and long term conditions, frailty, urgent and emergency care, maternity, children and young people, and people with comorbid LD and/or Autism and mental health.

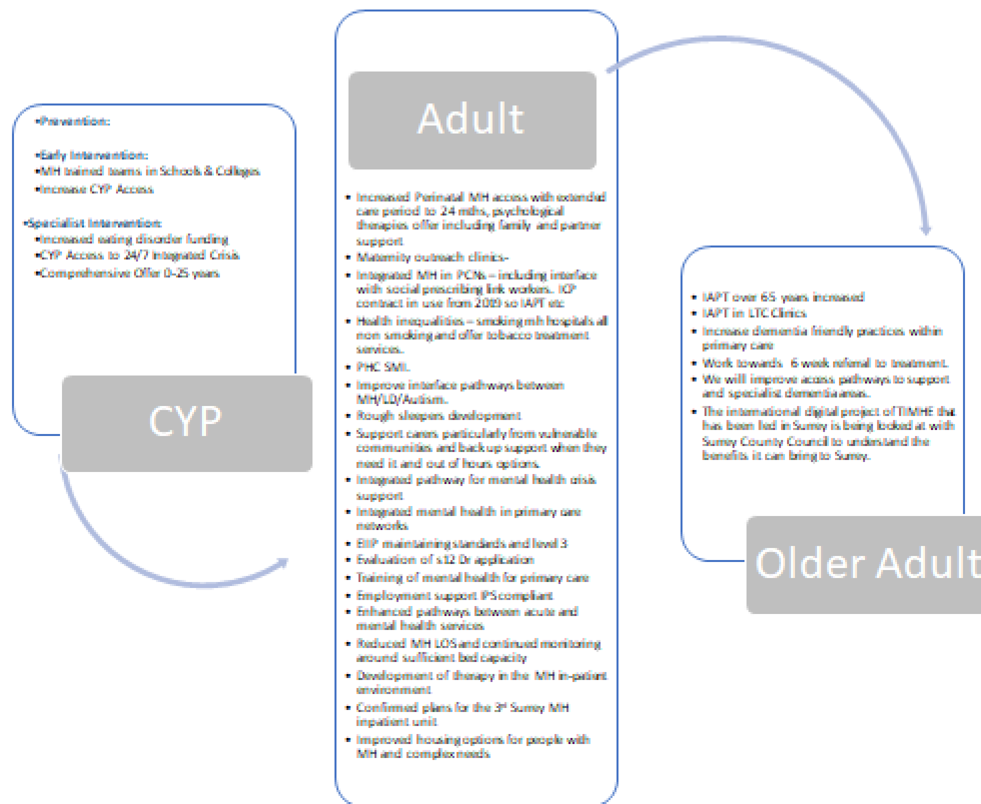


Figure 49

Key Actions 2020/21	Expected Improvements in Outcomes
Perinatal Increase PCMH staff to support expansion plan by 3 wte. **Community Transformation** • Total of 24 Primary Care Networks (PCNs) in place • Target our service better through using system wide population health data which help us identify and target inequalities. • Better utilise community assets, strengthening partnerships with the voluntary and third sector providers. • Support training of primary care workforce in mental health • Ensure IAPT trainees recruited to meet workforce for IAPT access expansion **Community Crisis** • Enhanced 24/7 hours of operation for CRHTT functions by March 2020 • Increased range of professional support within the HTT out of hours and at weekends.	**Community Transformation** • Community MH services provided to circa 6,435 people during 2020/21. • The average GP will be able to spend 5 to 7.5 more hours per week. • If MH cluster 1-3 patients are cared for in primary care, and 15% of patients in clusters 4-7 and 11-12 are stable to transition to our new community transformation model this would impact on an estimated 305 patients. **Community Crisis** • Increase capacity for addition 6,540 visits to people's homes evenings & weekends • Increased ratio of qualified workers per head of adult population, bringing the ICS close to 1 qualified worker per 12,000 (benchmark for a well-resourced team) • Reduction of people readmitted under s135 MHA • Increased leadership roles i.e. Peer Support Leader, Advanced Nurse • Enhanced support for people with EUPD who require intensive support

Key Actions 2020/21	Expected Improvements in Outcomes
• Provision for equivalent older adults CR/HT functions by March 2021. • Create a trauma informed network **Early Intervention in Psychosis (EIiP)** - Achieve level 3 – increase workforce **Serious Mental Illness Physical Health Checks (SMI-PH)** – continue the LCS in primary care **Individual Placement Support (IPS)** Achieve fidelity. Increase workforce. **Rough Sleepers** Map and raise awareness of existing pathways and develop Psychological Informed approaches that will better support people **Crisis Care via 111 and MH Ambulance** Work through pathway between 111 and MH SPA Joint training offer of MH for 111/999/SPA **MH Urgent and Emergency Care Standards** Pilot in the Frimley Health ICS the new UEC standards and apply the learning into Surrey Heartlands **Data Quality** Ensure data flow issues for EIIP and Perinatal resolved for MHSDS data to be accurate. IPS provider to submit data to MHSDS Continue to develop our approach to outcome monitoring and evaluation of our new models of care	• A service model that improves people's experience, supporting carers and sustaining people in their own homes rather than admitting them to hospital. **EIiP** • Retained staff returning from Cognitive Behaviour Therapy for Psychosis (CBTp) • Increased physical health checks and intervention • Increased access for people to IPS **111 and Ambulance** • Increased understanding and awareness MH across 111 and ambulance emergency workers **MH UEC Standards** • Test the current thinking to inform what future standards will be set for MH UEC • Increased visibility with standards recorded on integrated dashboard with acutes

Key Actions 2022/24	Expected Improvements in Outcomes
• Further rollout of community transformation with reshaping of CMHTs following learning applied • Delivery of Maternity Outreach Clinics • Development of crisis alternatives i.e. virtual safe havens • Increased offer in therapeutic inpatient environments • LOS and bed capacity analysis to support OAPs reduction and System pressure • Suicide reduction programme rolled out • 0-25 years service offer in place • MH UEC standards rolled out • Increased digital offer for therapy • Increased digital offer for staff	• Early intervention for MH • Reduced stigma and greater parity of physical health and mental health • Reduce the life gap for people with an SMI (to life expectancy of rest of adult population) • Increased access for perinatal women and partners • Reduction in suicides (NWS outlier: reduce from 11.1 to 7.4 per 100k population) • Improvement in transitions • Improvement on recovery and swifter discharge • Integrated dashboard for UEC • Reduced breaches in ED for MH • Increased productivity and compliance

Shorter waits for planned care

Across Surrey Heartlands we recognise that some services are more vulnerable in a range of factors including waiting times and patient experience; we call these 'fragile services'. The key challenge is often workforce and the impact creates fragmented services for our populations.

Our current proposal creates a multi-disciplinary professional team from each speciality across the Surrey Heartlands and Frimley Health Systems to reflect the whole pathway and explore it end to end.

For each speciality the group explores the challenges and applies best practice from other areas where collaborative or networked approaches have strengthened services. The key focus areas will be **Dermatology**, **Ophthalmology** and **Neurology**. It is anticipated that the programme will align with the local priorities for 26 weeks delivery, which presently includes Immunology, ENT, Gastroenterology and Ophthalmology.

NHS Operational Planning and Contracting Guidance 2019/20 states; "*Patients will continue to have choice at the point of referral and for 2019/20 new local arrangements must be put in place so that anyone who has been waiting for six months or longer for treatment must be specifically contacted by the provider on whose waiting list they appear or by the responsible CCG and given the option of faster treatment at an alternative provider*." Choice for patients at **26 weeks wait** is an offer in addition to the legal right to treatment at 18 weeks and does not change the current reporting arrangements around Referral to Treatment. The 26 weeks choice commitment will be applicable to those patients on an incomplete Referral to Treatment (RTT) pathway and therefore the nationally binding rules that currently exist will highlight the category of patients for whom this is relevant.

The 26-week Programme will work with all local System providers to ensure that citizens have care and treatment as quickly as possible and have options for additional service if the speciality service models are challenged. We will work with local Systems to ensure care remains coordinated and our citizens have access to high quality care and treatment. In addition, as part of our System solutions across Surrey Heartlands we will work as partnerships to reduce demand and transform services.

As a System, Surrey Heartlands continues to work to meet its constitutional targets and will deliver this through an elective care transformation programme. A number of projects are in place under this programme of work that will ensure:

- no patient will have to wait more than 52-weeks from referral to treatment (RTT)
- commissioning and provider organisations are working together to implement the choice process for all patients who reach a 26-week wait
- providers are able to deliver the 1% diagnostic target
- Systems are designed to enable capacity alerts
- actions are identified that will have a positive impact on reducing waiting lists
- there is access to First Contact Practitioners (FCP) for Musculoskeletal (MSK) problems

At a local level, ICPs are making use of existing sources of intelligence (local and national) to understand and plan for future elective care demand and the Systems are looking forward to developments in national tools, such as the emerging Model Health System products. Business intelligence is used to inform the planning, design and evaluation stage of all initiatives. As a minimum this includes:

- Baseline number of 52+, 26+ and 18+ waiters
- Benchmark against national datasets
- Model predicted elective demand
- Undertake an Equality Impact Assessment to ensure that the needs of population groups are understood
- Undertake citizen / patient / carer engagement to understand local service needs / demand
- Undertake targeted engagement with affected groups

Surrey Heartlands will be reviewing pathways which can only be delivered within acute settings to identify any opportunities for more efficient and sustainable ways of operationally delivery during 2020.

Systems are developing the capability to manage **Capacity Alerts**, in line with NHSE best practice guidance. CCGs and Providers are engaging to determine the areas for prioritisation and to agree on which specialties will be targeted.

Specific projects to oversee delivery of the required large scale changes include:

- **Population health management**: to aid understanding of future need and to enable predictive modelling. This will put the ICS in a strong position to accurately articulate its capacity needs and respond accordingly
- **Risk stratification**: (for frailty and for frequent attenders) has already begun and scoping around the opportunities in critical care for patients with a long length of stay is planned.
- **Referral support**: there are workstreams focused on maximising the value-add of Referral Support Services (RSS) and clinical referral triage, to ensure that referral quality is managed, diagnostics are best utilised and patients are aligned to the right pathway first time (or that secondary care referrals are avoided where at all possible). Key to success will be clinician behaviour change, in both primary and secondary care, and the programme of work will be closely aligned to the Surrey Heartlands Academy, to utilise this lever in ensuring that clinicians are well engaged in the education and support components of the programme.
- **Outpatient Transformation**: designed to meet the needs at Place and to contribute to the strategic goals at Scale, the overarching objectives of these programmes revolve around changing the way outpatients clinics are delivered to a more sustainable model.
    - Process improvements around use of eRS, the Booking Centre function and Informatics
    - New models of clinic will address current risk and waste, reduce clinically unnecessary face to face appointments and free up capacity to prioritise urgent appointments or elective procedures.
    - Expanding provision of digital and online services
- **Guidance from national leads and experts** e.g. the national pricing team, Future NHS Collaboration Platform, Elective Care Transformation Programme team is being utilised to ensure that the plans are informed by best practice and learning from experiences from across the NHS.
- **Piloting of First Contact Practitioner** with a focus on high impact areas.

Chapter 7: Supporting Our Workforce

Our vision is to have the right team, with the right tools and skills providing health and social care in the right place and at the right time, to meet the needs of the population of Surrey Heartlands.

We have had a number of achievements since our Workforce Transformation Mandate in 2016:

- A Workforce Board, jointly chaired by HEE and SRO for workforce. Members include HRD's and workforce leads from across the System (including VCFS), HEI's and trade union colleagues
- Developed networks of experts who have come together to deliver on our workforce mandate
- Written a workforce strategy, which underpins the programmes delivery
- Developed our relationships with ICP's, which is enabling us to develop our workforce at place
- Forming close links with neighbouring STP/ICS's which is enabling us to achieve collaboration
- Invested in a workforce team to deliver change programmes at place and scale
- A delivery plan for our transformational workforce interventions (appendix 13)

We still have work to and face a number of challenges that reflect our System and national situation.

Living and Working in Surrey
Recent Data suggests that Surrey is the most densely populated shire county in England, and has a population that is increasing year on year. With a higher than average life expectancy, lower levels of homelessness and violent crime and it's close proximity to London, more people choose to move here every year than leave. Surrey residents feel the burden of an increased cost of living, with the average home value in 2019 of £439,364 versus a UK average of £232,710. This high cost of living locally is just one factor that has impact on the ability of health and social care organisations to recruit and retain staff. The difference in London weighting between 20% uplift in inner London, to just 5% fringe that we see in Surrey, also makes taking up a role in London much more appealing. Despite 87% of Surrey inhabitants living in urban areas, public transport can be limited. Of those living in the more rural areas, 8% of households do not have access to a car, and of those households, 70% find themselves with more than a 30 minute journey to a hospital. This impacts on both workforce, and service users when considering where to settle.

Workforce demographics and our population
Although as a whole, the proportion of the population from minority ethnic groups is smaller in Surrey than the rest of England, this varies between local authorities and clinical commissioning groups. This provides a challenge to ensure that the needs of these small communities and individuals are appropriately met, both when planning care, and when recruiting into positions. Some minority ethnic groups may be hard to reach because of language or cultural differences which could then contribute to inequalities. An example could be our Eastern European groups, who may find the UK model of GP referrals into Specialist Teams confusing and therefore not access health services when needed. Although there is a lack of demographic data, it has been observed that the Traveller community in Surrey is another group that may experience barriers to health care, when considering the health status of these communities is generally poor, meeting their needs is an important consideration.

Local complexities of need
Surrey has a higher percentage of individuals in higher status occupations than in the rest of the UK. These senior roles bring with them a higher incidence of stress, anxiety and depression, which brings mental health support to the forefront of care delivery. Surrey, along with the rest of the UK, faces challenges related to the aging population. The proportion of those over 65 is predicted to increase from 18.6% in 2016, to 25.4% in 2041. This results in an increasing prevalence of conditions such as

musculoskeletal conditions, type 2 diabetes and cardiovascular disease. Therefore, we need to explore all opportunities to develop our workforce in relation to modifiable health behaviours.

Where we are now

- Difference between Establishment 2019 and Establishment 2024 shows a planned overall increase of 6.4% by March 2024. The difference between Trust Staff in Post (SIP) 2019 and Establishment 2024 shows a planned overall increase of 21.2%, as this takes into account vacancies
- Vacancies – 12.2% overall
- Apprenticeships – Nursing and Midwifery are to increase from 2.0 FTE Establishment 2020, to 10.00 by 2024
- Transformation Roles – PAs to remain at 0.0 FTE until 2021 when Establishment increases to 5.0 FTE and remains at 5.0 FTE until 2024
- Cancer – All professions show a steady increase in Establishment from 2019 to 2024
- Maternity and CYP – All professions show a steady increase in Establishment from 2019 to 2024.
- Mental Health – Clinical Psychologists Establishment to remain at 0.7 FTE until 2024. Psychotherapy Establishment to remain at 2.6 FTE to 2024, currently showing a vacancy of 0.2 FTE
- UEC – Emergency Medicine Consultants planned to decrease by -0.7 FTE (-3.7%) from 19.2 FTE Establishment 2019, to 18.5 FTE in 2024. With a current SIP of 14.5 FTE, this would still show a vacancy of 4.0 FTE

Primary Care Workforce

ICP Primary Care workforce compared to Surrey Heartlands and national averages[35]				
Area	**GP FTEs per 100,000 patients**	**% of GPs FTEs aged 55 and over**	**Nursing FTEs per 100,000 patients**	**% of Nursing FTE aged 55 and over**
England average	58	19.7%	27	33.3%
Surrey Heartlands average	53	18.6%	19	41.5%
Guildford & Waverley ICP	59	19.0%	21	30.3%
North West Surrey ICP	53	16.0%	17	41.2%
Surrey Downs ICP	48	20.8%	18	53.5%

(This work was undertaken before East Surrey joined the ICS, and will need extending)

The data shown in shaded boxes identifies where Surrey Heartlands ICPs (and Surrey Heartlands overall) are more challenged when compared with the national average.

The headcount of the overall GP workforce across Surrey Heartlands was 641 (476 FTEs) in September 2018. For Guildford & Waverley ICP the headcount was 176 (133 FTEs), which remained static over the 18-month period (March 2017 to September 2018); compared with North West Surrey ICP which has increased GP Headcount and FTEs by 35 and 32 respectively. (Note: The 176 headcount does not include 38 headcount recorded at RSCH within GP, Community and PH).

[35] Ashford and St Peters Hospital, Royal Surrey County Hospital, Surrey and Borders Partnership, Surrey and Sussex Hospital, CSH Surrey, First community Health and Care. They are taken from *'HEE Kent, Surrey and Sussex Assessment Summary of Trust Strategic Workforce Plans Following 1st Submission'.*

For Primary care practice nurses across Surrey Heartlands the headcount is 270 (167 FTEs). There has been an overall drop of 5% in headcount in the same 18 month period. For Guildford & Waverley this decrease in nursing workforce has been larger at 7% (from a headcount of 83 to 77), which was the biggest % decrease out of the three Surrey Heartlands ICPs.

Primary Care Networks (PCN) in Surrey Heartlands sees our practices working together in GP led PCN serving a combined patient population of surrey Heartlands (prior to East Surrey ICP joining) comprises of 91 practices with a total patient list size of almost 900,000. The model of between circa 30,000 to 103,000, which is the right size for developing highly effective, unified, multi-professional teams. The purpose of the PCN model across the System is to deliver integrated services to people in neighbourhoods as the foundation of an effective health System. People can access joined up proactive personalised care provided by practices. The opportunity to work at scale will bring resilience and access to a differentiated multi-disciplinary care team.

Our Imminent Plan is to:

- Maximise apprenticeship opportunities through other providers
- Develop non clinical roles (Practice Managers)
- Roll out medical assistant role following SH pilot align to other roles such as care navigator and social prescribing
- Road Shows to showcase benefits of new roles and their place in Multi-Disciplinary Team's (MDT)
- Maximise clinical pharmacist(CP) role to 1 CP per 15,000 population
- Expand the role of mental health therapist and IAPT
- Support employment of Physicians Associates and paramedics in GP, whilst mitigating the risk to SECAmb's workforce
- Develop Advanced Clinical Practitioner role; Multi professional highly trained autonomous
- Next Generation GP; First 5 years
- Scoping GP retirement numbers in the next 5 years
- Targeted interventions; portfolio career opportunities, reduce clinical sessions, identify reasons for wanting to leave and address.

Change Projects

The Workforce Transformation Programme has developed and commissioned projects and programmes of work to support our ambitions. All projects have an evaluation strategy and have been assessed on our Local Workforce Action Board (LWAB) Framework. Each project has a lead sponsor who sits on our LWAB and has the responsibility of providing assurance to the board. Our LWAB is chaired by Ashford and St Peters Hospital's Chief Executive Officer and Senior Responsible Officer for Workforce Transformation and the Regional Director for Health Education England, South East.

Recruitment	Transformation	Organisational Development	Early Careers	Primary Care & Training Hub
Step Into Health	Better Births	Mary Seacole Local	Nurse Associate Readiness Programme	Next Generation GP
HCA Recruitment Events at place and scale	At Place Workforce Plans	Affina Team Coaching	System wide Apprenticeship Strategy	GP resilience pilot
Collaborative recruitment website	Make Every Contact Count (MECC)	Mediation Training	Careers events development	Healthcare Support Worker Programme
Streamlining/ Passporting	VCFS Diagnostics	PeaKon		Mental Health First Aid Training

Recruitment	Transformation	Organisational Development	Early Careers	Primary Care & Training Hub
	Volunteering Workforce Development Programme	Surrey 500		Primary Care Workforce Plan
	EDI Strategy & Conference	Leadership and development programme for registered managers of care homes		CPD for non-medical staff
	Workforce Pilot for Winter Surge			
	Develop networks for collaboration			

Surrey 500

Surrey 500 is Surrey Heartlands' first large-scale leadership programme offering the opportunity for individuals to learn with colleagues working right across the System. The programme focuses on Systems leadership rather than the traditional theories of management and leadership. Participants are working together on how to become catalysts for change and action, and the programme is based on a successful model designed in conjunction with the Fylde Coast Integrated Care Partnership, Lancashire and NHS North West Leadership Academy which achieved demonstrable System change.

"*Setting up our own place-based collaborative leadership programme is helping us with our ambitions. It is an exciting opportunity for people to come together, be empowered as leaders and think across and beyond traditional organisational boundaries to achieve better outcomes for our citizens. Feedback from delegates so far is positive and I'm delighted that they are finding it valuable and beneficial."* Surrey Heartlands' Director of Transformation and the Academy.

Evaluation has just started on the cohorts, however anecdotal feedback from delegates received to date, indicates an improved confidence and better collaboration being two of the benefits of the Surrey 500 System leadership development programme.

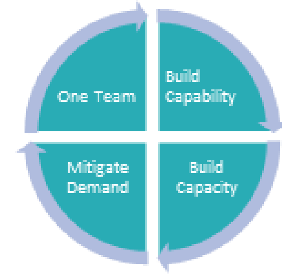
Joint recruitment events

We have piloted a joint HCA recruitment event in North West Surrey, consisting of Surrey County Council, Surrey and Borders Partnership, Central Surrey Health (CSH) and Ashford & St Peters Hospital. The aim was to utilise resources more efficiently and create a better experience for applicants, by having one event with multiple employers. We created a joint panel of interviewers and each organisation had information and resources for the candidates. The candidates were shortlisted prior to the event, however the event was open to potential applicants for information.

We advertised through a number of additional ways to seek candidates, such as Instagram, Twitter, and Google. Facebook yielded by far the most interest with 905 clicks. 21 candidates attended the events, with 18 of those being offered a role at one of the employing organisations. This equates to an 85% interview to appoint rate.

The staff needed for this event was significantly lower than if each organisation had their own assessment day. The candidates only sent one application and attended one interview, compared to a potentially four separate interactions. We will run these events across our other ICP's, more staffing groups particularly nursing.

Workforce Strategy
Our workforce strategy has four workstreams:



- Working as 'One Team'
- Building Capacity of our workforce
- Building Capability of our workforce
- Making Surrey heartlands the best place to work

Improving our Leadership Culture
We know that our leaders need to be supported better to lead our workforce. We have two programmes of work which focus on improving the leadership culture. The first is the Organisational Development (OD) Network, which focuses on designing and implementing System wide development programmes for leaders at all levels; secondly we have The Surrey Heartlands Academy, which aims to devise and develop a multi professional leadership approach. Within both of these programmes of work, we recognise that our leaders need to be more diverse, we are working on a metric to identify the diversity in our leaders, to ensure we are reflecting our workforce and population in our leaders. We're working to national drivers and frameworks to ensure our leadership team are reflective of both our workforce and the local population.

To support Local Authority and NHS integration Leadership capacities, we are seeking to appoint a Joint Workforce Director during 2020. Similar 'Joint Posts' will be in place for Estates and Digital programmes.

Current and future programmes of the Organisational Development Network include:

- **Team Coaching & Development:** using the Affina Team Journey, based on Michael West's compassionate leadership theories and practice
- **Mediation:** training and implementing a trainer mediator network, to be accessed by all organisations within the ICS
- **Local Leadership Development programmes:** for example Mary Seacole – trained Mary Seacole Facilitators from across the ICS to deliver local NHS leadership development programmes
- **Surrey 500:** A local System Leadership Development programme– designing and delivering a large-scale System leadership programme co-designed by ICS leads to support leaders from across the ICS to work together to provide better patient / citizen outcomes
- **Talent Management Framework:** the design and development of a talent management framework for the whole of the ICS, to allow the freedom of movement across organisations of leaders at all levels.
- **Managers Toolkit:** design of a new Managers Toolkit, using best practice from all participating organisations.
- **Coaching and mentoring framework:** the design and implementation of a local coaching and mentoring network to support all leaders across the ICS.

The Academy focuses on leadership culture and in particular aims to improve decision making and facilitate multi professional ownership of the challenge of tackling unwarranted variation. The aim is to extend clinical leadership to a multi-professional model that includes the wider workforce (for example nurses, AHPs). To support this, a training programme will be co-designed for leaders in these posts to equip them to deliver. A key role for these leaders will be to support all transformation work to be underpinned by a quality improvement approach as part of our quality management System.

Our outcomes in the next five years will include:
- Improved confidence in System working by individuals through the Surrey 500 programme
- Multi professional leads competency is demonstrated through a skills framework

- Improve System speed and effectiveness at removing unwarranted variation in care because of multi professional leadership and decision making, demonstrated through pace of change in clinical workstreams
- Demonstrable progress towards achieving NHS LTP clinical outcomes.

Building Capacity
We are developing a plan on how we can reduce the pressures sustainably on our current workforce for our future workforce by doing things differently.

- Developing new roles and pathways to reduce the demand on staff and promote better health outcomes for patients.
- Recruitment at place and scale to increase our current workforce and to remove duplication for applicants and competition for organisations, as well as promoting partnership working and trust.
- Bringing teams together to utilise resource more efficiently.
- Utilisation of current and future digital advances to enhance the way our staff are deployed.
- We need to workforce plan strategically and differently to be better at reducing our vacancy and skills gaps.
- If we want a fair deal for our staff we need policies and procedures aligned within SH
- As a System we contribute £3m every year in to our levy; we want to use the levy to develop new roles, new skills and a pipeline of health and social care staff
- Work with education to promote health and social care careers to school age children.
- We need to give staff the space to be innovative and develop new roles, products and pathways.

Building Capability & Mitigate Demand
We will build capability in our workforce by upskilling them and providing them with the tools and opportunities to develop and work at the top of their license. Following are some examples of how we are continuing to deliver this.

- To be able to respond to demand more efficiently, our staff need developed QI skills and innovative ways of working.
- Using GIRFT across the System to improve patient outcomes through the workforce using digital healthcare technologies
- Our workforce will understand how to be a System leader and what that means
- Staff will have a clear career plan and identify development opportunities with their managers
- Making Every Contact Count will provide staff with the information they need to ensure they have good health and wellbeing
- Developing our volunteers to be more resilient, provide more services and be able to provide the care they want to
- Use digital technology advancements to allow citizens to care for themselves more at home
- Provide our workforce with the right skills and tools for self-care and resilience
- Transforming service and roles by redesigning them, making visits into health care settings more effective

We are reviewing our operating model to develop a more sustainable and efficient model, in tangent with our ICS development, primarily working with our ICP's and the New Models of Care. The ongoing development of Primary Care Networks is an opportunity to provide workforce support in Primary Care, which supports the Transformation Plan. The table in figure 50 details how the workflow has changed, responding to demand.

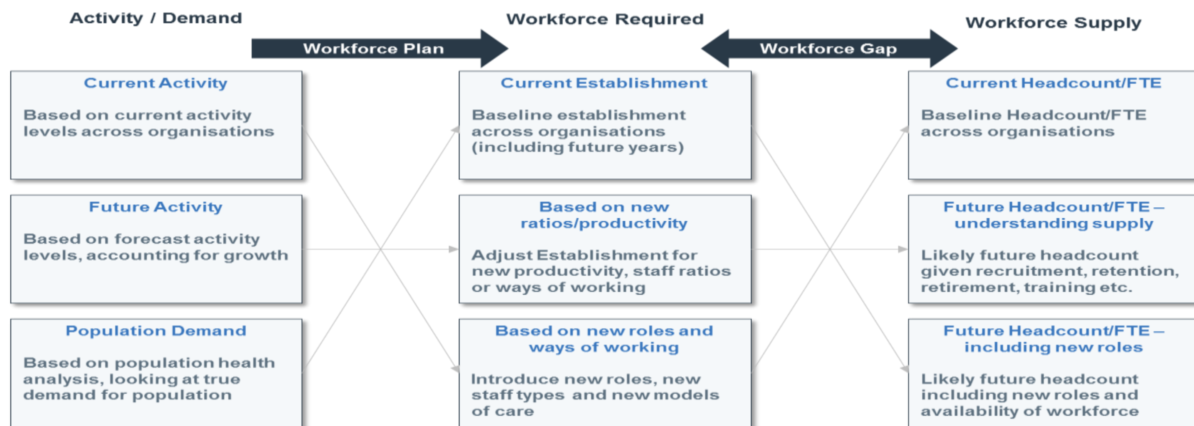


Figure 50

Making Surrey Heartlands the Best Place to Work

We want to be recognised as 'The Best Place to Work', to attract and retain staff from all professional, clinical and medical groups. To achieve this, we need to promote equal opportunities to all .We will monitor our progress by utilising the results from the staff surveys, reporting openly on our percentage of staff from protected characteristics.

- We are launching our Equality, Diversity and Inclusion Strategy in early 2020, this is to provide a clear agenda for Surrey Heartlands to promote EDI across our 'one team' ethos
- We are developing a 'Workplace Wellbeing' charter and framework to allow all staff directly or indirectly supporting patients to have the best working conditions and tools for self-care and prevention
- Our leadership development programmes have been specifically designed to equip leaders with the training, support and tools to be the best leaders and work in collaboration, as a System leader
- Staff have told us that they want their work to be meaningful, from delivering care, to commissioning services and all the other staff who work in care and health. We will give staff robust ways of working, and celebrate their successes and help them through their times of need through appraisals, management support, digital technology and wellbeing initiatives.
- Surrey Heartlands organisations will all offer equal opportunities' and not discriminate on any basis, all staff will have equal opportunities for development and be able to have the respect of their colleagues and citizens alike
- If staff wish to progress and develop into leaders or wish to develop in different ways professionally, they will the ability to use their experience and expertise to enable them to achieve their professional goals. We want to nurture their talents and develop their career pathways, to do this managers will need to be trained and provided with the tools to be able to support their staff appropriately
- We are working on a universal, System offer for staff in relations to pay and benefits. We want them to have the best possible deal
- We are working with registered managers in care homes to help them lead their teams effectively, to reduce turnover, provide staff with a better working environment and this has seen improved CQC ratings, this has been successfully rolled out in North West Surrey and is currently being rolled out across Surrey Downs and Guildford & Waverley ICP's
- We are working to allow our staff easier movement between organisations, this is being done in line with the National Streamlining Programme. As of April 2019, staff can move between five of our organisations without repeating Mandatory and Statutory Training

- We have an estates and digital strategy, and once fully deployed this will provide staff with better working infrastructure, allowing them to have more time to care

Within our priorities we promise to be fair, open and honest with our workforce and provide equal opportunities for current and future workforce. It's fundamental that each ICP and the ICS appreciates the rich talent supporting the System to develop a diverse workforce.

Employees will be aware of the Surrey Heartlands brand and objectives and feel empowered to make changes, and they will see their ICP and Surrey Heartlands leaders encouraging the development of integrated care solutions, enabling individuals and teams and role-modelling positive change behaviour.

Figure 51

As part of our EDI strategy development we have worked on a series of 'I' statements between the employer and the employee, such as:

- *I feel like I can bring my whole self to work – where I can truly be myself*
- *I feel like my differences are valued and my experience and input is appreciated*
- *I feel supported and represented by senior colleagues within the System*

These will be reviewed regularly and monitored to ensure they are true and reflective of how staff and employers are interacting.

Training Hub

The Surrey Training Hub (also known as Surrey CEPN) is an established group of like-minded individuals and organisations committed to developing the health and social care workforce across the Surrey Heath, Surrey Downs, North West Surrey and Guildford & Waverley footprints. The Training Hub aims to attract, develop, support and retain our health and social care professionals working across primary and community settings (for example GP surgeries, community clinics, care homes) throughout Surrey to ensure the provision of high quality care and services to patients.

This vision is delivered by:

- Coordinating and delivering training and education programmes
- Promoting multi-professional learning
- Improving integration and collaboration
- Responding to local workforce needs (including CPD and future planning)

Training Hub projects are aligned to local priorities set out by the Surrey Heartlands and Frimley Health and Care STPs (Strategy and Transformation Partnerships). Projects include:

- Launch of website to be used as central hub for training opportunities across the foot print
- Health Care Support Worker training programme
- EMIS training for GP practices
- Attendance at careers fairs, raising the profile of primary care
- Minor Illness module for practice nurses

Other Educational examples of current work:

- On-going HCA development programme for primary care, funded through Surrey Training Hub
- Mental Health First Aid training delivered to non-clinical staff working in care homes across Surrey
- Clinical Skills now starting to be offered across organisations, for example practice nurses accessing CSH wound care training, and non-medical clinicians being invited to attend Practice Supervisor training across all health organisations
- Non-medical prescribing updates at ASPH attended by NMPs in primary care
- Advanced practitioners across North West Surrey invited to attend Urgent Care training day

Digital Workforce
The Topol review, published in early 2019, focuses on Genomics, Digital Medicine, Artificial Intelligence and Robotics and the changes these have on our workforce. They play a big part on transforming our workforce in terms of efficiencies and quality. Surrey Heartlands has ambitious plans to use digital technology to support our workforce, fill skills gap and improve patient experience and care. We are underway with our digital strategy, which will outline our plans, alongside our digital transformation programme.

"The workforce is also changing: millennials have new expectations and most people seek a good work-life balance through flexible careers. The NHS Long Term Plan identifies the need for more healthcare workers to respond to this increasing demand. Digital healthcare technologies, defined here as genomics, digital medicine, artificial intelligence (AI) and robotics, should not just be seen as increasing costs, but rather as a new means of addressing the big healthcare challenges of the 21st century. The UK has the potential to become a world leader in these healthcare technologies and this Review anticipates how technological innovation will impact the roles and functions of healthcare staff over the next two decades. Our review of the evidence leads us to suggest that these technologies will not replace healthcare professionals, but will enhance them ('augment them'), giving them more time to care for patients. Some professions will be more affected than others, but the impact on patient outcomes should in all cases be positive. Patients will be empowered to participate more fully in their own care". Eric Topol[36].

Specialist Clinical Workforce
We have recruitment and retention challenges in key specialist clinical workforce. The delivery plans for mental health and cancer describe in this document their particular issues and improvement plans (Chapter 6).

Urgent Workforce Shortages
We have to do something today about our urgent workforce shortages. The following highlights delivery plans for specific areas of challenge:

Nursing vacancies

- Working with HEIs to ensure rich placement experiences for under graduate student nurses
- Attendance at HEI careers fairs aimed at third year student nurses
- Joint recruitment events

[36] (Topol)

- Currently looking into the potential for rotational programmes which will allow nurses to cross organisational boundaries during their rotation
- Development of practice nurse bank

Skills mix and workforce redesign

- Beginning work with organisations to facilitate looking at transforming the workforce by identifying how teams can be built around the needs of their population, rather than filling pre-existing vacancies
- Nursing Associate Apprentices now being piloted in primary care
- Advanced Clinical Practitioner role being developed in Primary Care by utilising HEE funding for ACP MSc

Allied Health Professional

- Enabling clinicians to work at the top of their licence, and considering succession planning as individuals move into advanced roles

Primary Care: not replacing GP's with GP's

- Working with practices to extend the scope of their current non-medical workforce
- Introducing new roles in line with national approaches

Workforce Redesign
Working System wide we will identify the areas of good practice and the areas which need support to determine where we can provide a better model of care, by developing new roles and upskilling of the existing workforce to meet specific population needs. They will also help us to address our workforce shortages and reduce our reliance on agency workers.

- We will explore workforce redesign options against clinical pathways alongside clinical transformation workstreams, where developing and utilising workforce in different ways and places across the patient journey will enable greater impact and outcomes for the population.
- Through workforce redesign we aim to build the team around the person with health and care needs, redistribute workload around the team and support and develop the enablers that facilitate this. Commenced with Advanced Clinical Practice (ACP) conversations targeted at Frailty and urgent and emergent care.
- To do this we will work with Health Education England using the 5 workforce enablers of the HEE STAR and the patient and learner journey concept maps to develop career pathways that support the above. This is already happening within maternity LMS
- We will identify areas of upskilling and development of knowledge, skills, behaviours and capabilities in existing and future workforce that will support population needs. For example; patient centred care, population health, self-care and prevention, learning disabilities and autism awareness, Mental Health, Cardiovascular.
- We will determine ways in which we might enable this across the learner journey by sharing resource across the System and accessing and implementing national resources at place.
- Other options to be considered are; educational supports and resources, innovation in practice, career development, overseas recruitment- earn, learn, return options, retire and return options, supervision and assessment, rotational programmes to build capabilities and skill sets.

Growing our own Talent

We have developed an 'Apprenticeship and Early Careers' plan; and resourced a team to work alongside Education and Training sector to provide a pipeline of new candidates into health and social care roles.

Get Ready	• Establish a System-wide approach to ensure we have a pipeline of new recruits entering careers in health and social care from our local communities • Enhance schools and college engagement to maximise resources and impact, and increase the no. of organisations offering work experience/ work placements/taster sessions • Engage with T level providers to ensure programme meets ICS requirements, and with all organisations across SH to ensure there is capacity to meet the demand for T-levels placements by sept 2020
Get In	• In line with SCC Health and Wellbeing Strategy, and to support access to opportunities for personal fulfilment, we aim to create an ambition for increasing a range of employability programmes, work placements and supported internships that recognise and reduce disadvantage and inequality.
Get On	• Apprenticeships are popular with older entrants and attracts people from diverse backgrounds therefore, as part of a broader strategy to increase social mobility and widen participation and inclusion, we aim to support the workforce through the roll-out of apprenticeships at all levels • Develop an ICP wide Functional Skills programme to remove this existing barrier to apprenticeship programmes • Establish effective working relationships with HEI's to influence curriculum, and development of new standards, for new and existing roles identified through ICS and ICP development
Go Further	• For Surrey Heartlands to work together to increase the number and range of high quality apprenticeship programmes including registered roles. A SH wide cohort of OT's is developing for a sept 2020 start • Efforts will be focused on addressing the nursing workforce challenge by increasing in the number of Trainee Nursing Associates and Registered Nurse Degree Apprenticeship across the ICS. This is particularly challenging due to number of protected learning hours, or Supernumerary hours, required to meet the Nursing and Midwifery Council (NMC) standards • Maximising use of the Apprenticeship Levy across the System, to reduce underspend, and ensure that small organisations and non-levy paying organisations can access • Establish a System for SME to request Transfer of Levy from partner organisations to ensure it is used to develop the SH wider workforce

Risks to delivery

Risk	**Mitigation**
Developing new roles has a long lead time; and potentially new training	We are working with HEI's and training providers to ensure we have the right set up when we want to develop the new roles
HRD's have not been given System responsibilities; therefore they are not engaged and delivering System wide benefits-we have to seek HR expertise outside the System	Developing a HRD Network
No Workforce Director in post	The job is being advertised through executive search firm NB joint role with Surrey County Council
Growing demands on services is stretching our workforce further	Mitigating demand is one of our strategic priorities
Funding reduced for workforce programme from HEE	The ask to the ICS for Transformation funds
Streamlining of services; challenges with IT and clinical processes	Working with digital and clinical teams pathways to develop innovative ways of working

Chapter 8: Digitally Enabled Care

By March 2024, there will be comprehensive digitalisation across the System with locally shared records supporting high quality care. We will have a digitally skilled workforce, with centrally delivered capabilities enabling new service models. Citizens will have digital care plans and personal health records and be involved in co-designing to ensure digital designs and solutions are safe, ethical and effective. We will have actively worked to minimised digital exclusion to optimise opportunities to benefit from digital solutions.

Surrey Heartlands' Digital Strategy (appendix 16) was developed in 2017 and updated in 2019. It aligns to the NHS Long Term Plan and is supported by a Technology Roadmap that is currently being refreshed.

The Digital Strategy sets out a range of initiatives that will transform the delivery of services in Surrey Heartlands in a number of ways including:

- **Integration:** using connected, interoperable systems to share data and support consistent processes and services
- **Digital access to services:** allowing Surrey citizens to access health and care services via mobile devices and digital channels in the same way as they already access day-to-day services in other aspects of their lives
- **Safety:** ensuring that clinical safety is designed in to new systems and technologies
- **Cyber security and data protection:** keeping the personal and sensitive data of citizens and staff safe and secure and giving assurance that it is being used only for correct, approved purposes
- **Infrastructure and performance:** Initially at primary care level, work with ICPs, GP Federations and system suppliers to optimise existing investment

The Digital Strategy recognises the importance of digital initiatives in enabling the Surrey Heartlands' transformation agenda.

The emergent Surrey Heartlands Technology Roadmap will build on the Digital Strategy and set out the key technologies that will be implemented across Surrey in the next five years. The exact timings for delivering some of the initiatives discussed in this Chapter are still being developed, but the priorities for the next 18 – 24 months are:

- Addressing known cyber security vulnerabilities and building a culture of cyber-awareness
- Enhancing Primary Care infrastructure
- Building the Graphnet platform that will enable effective sharing of information and using it to make health and care information available to as many appropriate care professionals in Surrey as possible
- Delivering a common clinical systems platform across Surrey acute hospitals
- Providing Surrey citizens with a range of digital channels through which they can access services and with apps or portals to allow them to access their own health and care records

Each of the above initiatives is of value in itself and will deliver tangible benefits, but in combination they can be truly transformational. For example, improving local systems and processes can deliver efficiencies and improved outcomes, but the combination of this work with initiatives that enable new models of care and build capability in understanding and managing population health will make a significant contribution to Surrey Heartlands' ambition to reduce outpatient attendance.

As well as implementing new or improved technologies in defined areas, Surrey Heartlands will seek to build the digital capability required to deliver, operate and improve compliant, modern, fit-for-purpose IT architecture and services so that users from back-office to the front-line can embrace new efficient and effective ways of working.

Integration

Integration is key to delivering Surrey Heartlands' digital ambition and a number of initiatives are already underway that will join core systems together, improve interoperability and facilitate sharing health and care information:

- Surrey's Acute hospital providers are either installing or upgrading their clinical systems to the Cerner Electronic Patient Record (EPR) solution, significantly raising HIMSS maturities from c.2 to Level 7. This will be a UK-first as the Surrey and Sussex, Ashford and St Peter's and Royal Surrey Trusts will be operating the same up-to-date version of the EPR software and accessing common databases, enabling joined-up working, not only within individual acute hospitals, but across the wider Surrey health and care network. EPR implementations will conclude in December 2021, with full rollout and exploitation following that.
- An electronic maternity record will be designed and implemented at Surrey and Sussex Hospital Trust in order to bring it into line with other Surrey Heartlands Acute hospitals and provide a consistent service.
- The Surrey Care Record will use Graphnet's CareCentric platform to allow health and care professionals to view shared information. From early 2020 the patient records held by more than 80% of Surrey GPs will be shared via the Graphnet platform and will be readable by acute hospitals, Pharmacists, Community Health, Mental Health and Social Care professionals. Graphnet data feeds will also make records from these providers available so that care decisions will increasingly be made on the basis of the fullest possible set of patient information. As well as making information available to health and care professionals across Surrey, CareCentric also offers functionality that supports the workflows and integrated processes that will allow multi-disciplinary teams to collaborate in real-time.
- As one of the first national Local Health and Care Record (LHCR) exemplars, the Thames Valley and Surrey (TVS) partnership's Local Health and Care Record (TVS LHCR) will provide an integration platform for care records from within Surrey with those in the rest of the TVS area and will ultimately allow care records to follow patients as the move or are treated nationally. By April 2020, all participating bodies will provide a baseline set of data to the LHCR. In the months that follow, the range of data sets will increase as further interfaces are developed and data sharing agreements put in place.

Surrey Heartlands is firmly established as one of the key partners within the Thames Valley Surrey LHCR which will implement the Graphnet Platform by the Summer of 2020 as part of the first wave of LHCR formations. Teams from Surrey Heartlands work closely in partnership with the regional team and share resources, infrastructure and process wherever possible.

The new Graphnet and EPR platforms will increasingly tie together the organisations that comprise Surrey Heartlands and enable them to work as one virtual team across Surrey.

Digital access to services

During 2020/21 Surrey Heartlands will enable people to access communications from their care professionals and at least some elements of their care plans through a Personal Health Record (PHR) app. While the baseline functionality is being deployed to citizens across Surrey, the system interfaces, processes and user experiences required to support people with long-term conditions will be developed and implemented in a phased delivery.

A full set of requirements for a PHR solution has been developed and these will now be used as the basis for selecting the preferred software product. Development and implementation of the solution will focus initially on a 'standard' configuration and one tailored to supported self-management for people living with breast cancer. This latter configuration and approach will inform the subsequent development of PHR functionality and data feeds to support other tumour types and other long-term conditions.

Procurement is underway to enable online consultation or triage for Surrey citizens seeking Primary Care. Initially, this will be text-based; in subsequent phases audio and video consultation will be made available. These deployments are scheduled to be completed in 2020. System-led online consultation solutions will seek to maintain the relationship between citizens and their local Primary Care providers.

Surrey Heartlands will soon start to trial the new Care UK Telecare wearables service for 500 frail patients across Surrey. This will allow us to manage patients at a distance - dramatically reducing the onerous burden on both them and staff as they attend routine monitoring appointments and providing reassurance to both them and carers that care professionals are watching over them. An additional benefit is that significant real-time data will be collected to gain further insight into their conditions and the efficacy of any additional treatment regimens that are put in place.

Cyber security and data protection
With such rich personal data within key systems, Cyber Security is a key issue for the System. Surrey Heartlands is seeking to address its ageing infrastructure, software and digital workforce challenges, so recognises that it needs to significantly invest in specialist advice, process and countermeasures over the life of this plan. Such cyber capabilities are best delivered as a system-wide function working with specialist partner organisations to improve security across Surrey. Once established, this central function will lead on developing resourced plans to ensure all providers within the System meet the minimum NHS Data Security Standards. Key activities in the next 18 months will include:

- **Priority fixes**: identifying the highest risk vulnerabilities that must be addressed by the end of 2019/20
- **Harmonising guidance**: ensuring that a consistent message is being communicated to staff and partners across Surrey Heartlands regarding cyber security
- **Education**: people are the most important component of effective cyber security, so a programme of education will be developed and rolled out during 2020 in order to raise awareness of risks and of the steps that everyone can take to reduce the risk of cyber attack

The Data Security Protection Toolkit (DSPT) will be used to conduct annual assessments and ensure System-wide readiness for the Cyber Essentials Plus assessment in summer 2021.

To ensure a clear and consistent message for our citizens we will develop a single consent framework to guide all sharing of data.

Information governance and data protection
With such an increasing agenda for sharing personalised and pseudonymised data across partners within and beyond Surrey borders, Surrey Heartlands ICS has invested in bolstering central team to work in hand with the sovereign organisation's teams. Such alignment will ensure clear and consistent messages for our citizens, staff and partners, and will adhere to a single framework for sharing of all data we are developing.

Clinical safety
The increasing aggregation of personalised data and the application of heuristic and algorithmic problem-solving rules to aid clinical decision making, means that clinical safety of such new systems and practices is paramount. Our CCIOs and CIOs will work collaboratively to ensure that it is a primary consideration in the assessment of all proposals for new systems, technologies and associated

processes throughout. A robust framework and trained Clinical Safety Officer cadre of staff will be in place within 2020.

Infrastructure and performance
As we seek to deliver more citizen-facing services digitally, it is essential that service providers' infrastructure is capable of running modern applications, supporting video calling or the sharing of high-resolution images. Work is already underway to improve the hardware and infrastructure in Surrey Heartlands GP practices. This will continue through 2020.

Network speed and bandwidth can often be the 'weakest link' in the digital chain. We will develop plans to deliver improved network wired and wireless access to all clinicians and care providers in Surrey, wherever they need to work.

New rich digital apps will support the workforce whilst out in the community. There are plans to pilot these throughout 2020.

With the merger of the 4 Surrey CCGs to form a single Clinical Commissioning Group, work is underway to harmonise the file structures as a first step to making it easier to share information between Commissioning staff by April 2020.

As part of each implementation or upgrade of new systems, Surrey Heartlands will seek to replace existing paper-based processes with digital workflows and to digitise paper records.

A comprehensive NHS England sponsored Population Health programme is underway, working with Optum to significantly upskill both Analyst and Insight capabilities amongst users of Population Health data by August 2020. Plans are built into digital roadmaps to fully operationalise and exploit the new dashboard capabilities within the new Graphnet Platform and consolidate both BI Tools and deep analytic tools by December 2020.

Building digital capability
A number of digital initiatives are already underway across Surrey Heartlands, including projects that will enhance infrastructure, improve integration (between systems and between partners) and enable citizens to access services digitally. These are currently being undertaken within the existing structures and using existing IT and digital capabilities of eight sovereign organisations and a small central Surrey Heartlands Digital team.

Maximising the return on investments in digital and ensuring that enabling programmes and projects are delivered effectively and at pace will require a genuinely System-wide approach and the right resources and capabilities. Key components of this approach are:

- **Deploying the right resources**: fully-resourced plans will be developed for each digital initiative and will form the basis of prioritisation of the digital portfolio, based on benefits and other impacts
- **Addressing capability gaps**: where individual partners lack required skills and capabilities, these will be met first, where possible, from within other Surrey Heartlands partners. Where necessary, central capabilities, for example in Cyber Security, Enterprise & Technical Architecture, Project Management or Business Analysis, will be recruited. The Digital Workstream will seek to adopt proven methodologies and approaches that are already in use in other sectors, such as User-centred Design
- **Giving teams the right tools**: effective, co-operative working between digital teams from multiple organisations will require improved collaboration platforms to allow effective sharing of information, joint working on documents and the ability to 'crowd source' problems or seek advice from common interest communities
- **Refreshing governance arrangements**: the Surrey Heartlands Digital Programme Board will reconvene in November 2019 and will provide oversight and assurance for in-flight programmes

and projects as well as making recommendations to the Surrey Heartlands Executive for future digital initiatives, policy direction and areas for investment

Each of the partner organisations are at different levels of digital maturity. The Surrey Heartlands Digital Programme Board will set challenging targets for digital maturity, including mechanisms for assessing their achievement, that reflect the NHS Technology Vision and the practical priorities set out in the Long Term Plan. These targets will be used to expand on and refresh the portfolio of digital projects that will enable Surrey Heartlands transformation agenda and to measure progress in achieving the desired outcomes.

Surrey Heartlands already complies with NHS interoperability standards as part of its alignment between its procurement and technology teams. The System's Digital Programme Board will further embed these standards across partner organisations by agreeing a definition of the standards that will apply to relevant technology initiatives and the controls that will be used to assure compliance.

Co-operation between the sovereign organisations that comprise Surrey Heartlands is increasingly being enabled by working-level engagement on individual projects and by regular CIO and CCIO meetings and conference calls.

In addition to digital-focused governance, work is underway to establish System-wide forums that will provide oversight and assurance related to clinical safety and a consent framework for information sharing.

The sovereign organisations that comprise Surrey Heartlands account for significant spend with a range of technology companies and service providers. The Digital team will conduct an assessment of opportunities to better leverage that scale in order to secure improved services and value for money.

Key risks

The initiatives outlined in this chapter represent major change. The TVS LHCR, the Surrey Care Record and EPR implementations alone are all multi-year, multi-million pound undertakings. There is also a high degree of interdependence between initiatives. For example integrating the Graphnet platform with emerging designs for EPR solutions will be essential for both the Surrey Care Record and the TVS LHCR. Similarly, the realising Surrey Heartlands' ambition for transforming outpatient care will require the delivery of effective online consultation and telecare solutions and the availability of user-friendly citizen facing apps and portals.

In order to address the risk that collective digital delivery capacity is insufficient, the Surrey Heartlands Digital Programme Board will play a key role in prioritising and co-ordinating the projects and programmes that will deliver digital transformation and in providing oversight and approval of emerging technical designs via a Design Authority function. The Digital Programme Board will be the vehicle for promoting a collaborative delivery culture across sovereign organisations, based on the principles set out in the Partnership Memorandum of Understanding.

In addition to the development and integration of new technologies, the initiatives described out in this chapter also represent significant change for people, both staff in NHS partner organisations and Surrey citizens. Individual projects, and the Digital workstream as a whole, need to recognise this and ensure that their project plans and structures reflect the need for targeted business change activities and for effective campaigns of citizen-facing communications and engagement.

Chapter 9: Taxpayer’s Investment Will Be Used to Maximum Effect

Financial Sustainability

Historically, the organisations within the Surrey Heartlands system have collectively met financial targets delivering the system Control Total in 2017/18 and 2018/19. This position has been delivered through non recurrent measures including significant profit on land sales and additional financial incentive reported within the year end position each year.

There has been significant pressure on Commissioner budgets including rising non elective activity costs, pressures on prescribing budgets, slippage on planned service transformation programmes and a trend of high acute activity costs across all Commissioners. This has resulted in an adverse position against the Commissioner Control Totals over the last 2 years.

Providers have reported favourable performance against control totals however this has been through a number of non-recurrent actions including the sale of land within Ashford & St Peters Trust and Surrey & Borders Partnership Trust.

As a result of the non–recurrent element of delivery of the System control total to date, there is significant pressure in 2019/20 and moving forward in the 5 year plan. This coupled with rising demand for services is providing a significant system challenge. There is a substantial level of risk across the system reported outside of the 19/20 forecast which impacts on the 2020/21 financial plan. The system recovery plans will continue to identify schemes to bridge the financial. The system is still working to identify further non-recurrent measures to mitigate the 2019/20 position including exploring support opportunities from Surrey County Council. This underlying position creates considerable pressure in 2020/21 and subsequent years compared to the system trajectory targets.

There is a collaborative approach to system working with an established Finance Partnership Board working to deliver System targets and address financial balance, incorporating new system partners with East Surrey CCG and Surrey & Sussex Healthcare.

Ambition

Moving forwards into the 5 year planning period, the system has been provided with financial trajectories resulting from regulator modelling work to meet the tests around returning the NHS into overall financial balance by 2023/24. There has been considerable collaborative work across the system to align financial assumptions and identify opportunities for delivering system efficiencies in order to meet the significant financial challenges faced.

		Total ICS			
£m	**FOT 19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Surplus / (Deficit) (including incentives)	**5.6**	**(50.1)**	**(31.8)**	**(6.9)**	**2.7**
Surplus / (Deficit) (excluding incentives)	**(27.9)**	**(62.4)**	**(44.4)**	**(19.8)**	**(10.4)**
System Trajectory*	(1.5)	(9.5)	(3.7)	0.6	2.7
Gap to system Trajectory	7.1	(40.5)	(28.1)	(7.5)	(0.0)
System Efficiencies					
Savings in plan - Commissioner 1%	36.9	14.2	14.8	15.3	15.8

Savings in plan - Recurrent	29.9	27.2	24.6	26.7	27.1
Savings in plan - Non Recurrent	9.2	6.0	6.2	6.4	6.5
Savings in plan - Other	32.0	0.0	0.0	0.0	0.0
Total Savings in plan	**107.9**	**47.5**	**45.5**	**48.4**	**49.4**
Savings %		**1.5%**	**1.4%**	**1.4%**	**1.4%**

The ICS is committed to resolving the underlying position and addressing some of the embedded structural financial issues through the transformation of services outlined in the 5 year plan and the 10 year strategy. **The modelling outlines a reduction from a £50.1m deficit (including incentives) in 2020/21 to £2.7m surplus (including incentives) in 2023/24 reflecting our intent and aspiration to return this System to balance within the life of this plan.** These plans assume that Surrey Heartlands ICs will receive the £25m of local devolution transformation funding in 2020/21.

The provider positions are broadly in line with system trajectories and deliver to plan across the financial planning period. By 2023/24, the in-year Provider position delivers a £6.4m surplus against the trajectory of £5.6m surplus (£0.8m favourable performance variance). Savings vary slightly across provider organisations ranging from 1% to 3% across the planning period.

From an ICP funding and population based budget perspective the positions demonstrate the intention to deliver an improvement in the financial performance across the planning period. Within the financial plans, the CCGs reduce the level of year on year deficit with Guildford & Waverley CCG and North West Surrey CCG achieving the financial trajectory by the end of the planning period (2023/24).

	ICP Level - G&W			
£m	20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	(6.7)	(2.2)	0.7	2.6
Surplus / (Deficit) Provider	2.7	2.4	2.2	2.7
Surplus / (Deficit) ICP level	**(4.0)**	**0.2**	**2.9**	**5.3**
Joint ICP level System Trajectory*	0.1	1.7	3.2	4.6
ICP Gap to system Trajectory	(4.1)	(1.5)	(0.3)	0.7
Joint System Efficiencies				
Savings in plan - Commissioner 1.0%	2.8	2.9	3.0	3.1
Savings in plan - Provider Recurrent	6.0	6.2	6.4	6.5
Savings in plan - Provider Non Recurrent	6.0	6.2	6.4	6.5
Savings in plan - Other	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**14.9**	**15.3**	**15.7**	**16.1**
Savings %	**2.1%**	**2.1%**	**2.1%**	**2.1%**

Guildford & Waverley ICP modelling outlines a reduction from a £4m deficit in 2020/21 to a £5.3m surplus in 2023/24.

	ICP Level - NWS			
£m	20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	0.1	0.4	2.8	6.2
Surplus / (Deficit) Provider	1.6	1.3	1.9	1.8
Surplus / (Deficit) ICP level	**1.7**	**1.7**	**4.7**	**7.9**
Joint ICP level System Trajectory*	1.6	1.6	1.7	1.7
ICP Gap to system Trajectory	0.1	0.1	3.0	6.2
Joint System Efficiencies				
Savings in plan - Commissioner 1.0%	4.9	5.0	5.2	5.4
Savings in plan - Provider Recurrent	5.3	3.8	5.7	5.9
Savings in plan - Provider Non Recurrent	0.0	0.0	0.0	0.0
Savings in plan - Other	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**10.1**	**8.8**	**10.9**	**11.3**
Savings %	**1.1%**	**1.0%**	**1.2%**	**1.2%**

North West Surrey ICP modelling outlines an improvement in the position from a £1.7m surplus in 2020/21 to a £7.9m surplus in 2023/24.

Surrey Downs ICP has a challenging trajectory and although this is not delivered within the planning period, there is a significant reduction in the year on year deficit moving from £14.9m deficit in 2020/21 to a position of breakeven in 2023/24. This represents a significant improvement in the underlying year on year position.

	Commissioner Plans - SD			
£m	20/21	21/22	22/23	23/24
Commissioner Allocation	451.3	463.3	482.1	498.2
Commissioner Expenditure	(466.2)	(473.2)	(485.7)	(498.1)
Surplus / (Deficit) (excluding incentives)	**(14.9)**	**(9.8)**	**(3.7)**	**0.1**
System Trajectory*	2.4	4.2	4.4	**4.5**
Gap to system Trajectory	(17.3)	(14.0)	(8.1)	(4.4)

This is Surrey Downs CCG only as Epsom & St Helier Trust is not within the Surrey Heartlands ICS Control Total position.

The modelling outlines a reduction from £14.9m deficit in 2020/21 to a £0.1m surplus in 2023/24.

East Surrey ICP are unable to meet the trajectory across the planning period although considerable improvement is expected, reducing the in-year position from a deficit of £27.1m in 2020/21 to £10.6m deficit in 2023/24.

		ICP Level - East Surrey			
£m	FOT 19/20	20/21	21/22	22/23	23/24
Surplus / (Deficit) Commissioner	(22.1)	(30.6)	(24.9)	(18.3)	(12.5)
Surplus / (Deficit) Provider	14.0	3.4	2.7	1.8	1.9
Surplus / (Deficit) ICP level	**(8.1)**	**(27.1)**	**(22.2)**	**(16.5)**	**(10.6)**
Joint ICP level System Trajectory*	0.9	(10.4)	(9.5)	(8.7)	(8.1)
ICP Gap to system Trajectory	(9.0)	(16.7)	(12.7)	(7.8)	(2.5)
Joint System Efficiencies					
Savings in plan - Commissioner 1.0%	2.8	2.5	2.6	2.7	2.8
Savings in plan - Provider Recurrent	6.0	3.9	4.2	4.4	4.7
Savings in plan - Provider Non Recurrent	0.0	0.0	0.0	0.0	0.0
Savings in plan - Other	2.8	0.0	0.0	0.0	0.0
Total Joint Savings in plan	**11.7**	**6.4**	**6.8**	**7.1**	**7.5**
Savings %		**1.0%**	**1.0%**	**1.0%**	**1.0%**

East Surrey ICP modelling does not include Horsham, Crawley and Mid Sussex CCGs as they are not in SH ICS control totals.

The system financial plan meets the overall total trajectory in 23/24. The gap ranges from £40.5m in 2020/21 reducing to meet the trajectory of £2.7m surplus in 2023/24 which reflects a significant reduction in costs across the 4 years. Submissions reflect a level of ambition for the delivery of efficiency savings and this requires acknowledged system working to remove real costs from the system and deliver transformational change at scale.

Commissioner savings has been planned for delivering a reduction in expenditure of 1% of allocations. This represents c. £14m of savings to be released from Non acute expenditure across the system and predominantly focuses on efficiency programs across Continuing Healthcare and Medicines Management.

In addition to the 1% savings assumption the financial plan assumes Financial Recovery plan savings of c. 1%. where required. In some systems, this is a year on year requirement in order to deliver the system trajectory. This challenge represents a cost savings of c. £15m per year which despite sitting within the Commissioner plans, represents the requirement to develop robust local ICP Financial Recovery plans.

The financial plans assume that local ICP systems will deliver Financial Recovery Plans across all Commissioning and Provider organisations looking at a number of interventions and identifying potential benefits to be investigated. This further work is acknowledged in developing the plans to address the overall system gap and to deliver further benefits and work towards the ambition of financial sustainability. These assumptions have only been built into local partners' financial plans and activity assumptions where they have been formally agreed through ICP Boards. As we develop our local operating plans, the scale of transformation will need to be explicitly reconciled across the systems.

This work will build upon the 2019/20 Financial Recovery Plans that have been developed for this year and the following year. Whilst it is acknowledged that this is a start, these plans need to be progressed to cover the 5 year planning period and to determine how the system can reduce real costs across all organisations. This work is already in progress with local ICPs and a system wide services review covering all areas that impact on the system. We are building on the 2019/20 work to develop explicit System Recovery Boards with multi-year recovery plans for our ICPs that our projecting deficit positions. This process has been agreed between Surrey Heartlands and Sussex for the East Surrey ICP and with South West London for the Surrey Downs ICP. The overall recovery plan will be supported by the transformation support unit across the ICS for the major transformation project outlined in this plan.

The approach to financial planning represents a fundamental change to the care model and different ways of working. System partners will move away from the traditional Payment by Results model of contracting to a cost based system, working collaboratively to deliver efficiencies across the system in order to reduce expenditure growth.

The System has continued to use all national modelling tools to develop its plan including RightCare analysis, GIRFT and Model Hospitals. The system will develop further efficiencies across organisations to support the strategies outlined in this plan. Devolution opportunities will be maximised and the vision for our estate will be a combined NHS and local Government estate to create "one public estate" at scale with local control.

Activity plans and projections have been developed at a local level based on population projections and growth trends.

The table below illustrates the activity growth rates across Points of Delivery, which has been consistently applied from 2020/21 to 2023/24.

POD	ASPH	RSCH*	SASH		CCGs
GP Referrals	+2.4%	-2.6%	+5.0%		+1.3%
Other Referrals	+2.4%	+2.4%	+5.0%		+3.0%
Consultant-led first outpatient attendances	+3.8%	-2.6%	+5.0%		+2.8%
Consultant-led follow up outpatient attendances	+3.8%	-2.6%	+5.0%	→	+2.7%
Elective Spells – Day cases	+3.8%	0.0%	+5.0%		+3.2%
Elective Spells – Ordinary spells	+3.9%	0.0%	+5.0%		+3.1%
Zero length of stay spells	+2.4%	+2.4%	+5.0%		+3.0%
1+ day length of stay spells	+2.4%	-2.6%	+5.0%		+1.7%
A&E Attendances - Type 1 & 2 attendances	+3.8%	-0.5%	+5.0%		+2.9%
Other A&E Attendances	0.0%	-0.5%	+5.0%		+1.5%

Strategic and operational interventions to mitigate these have been included where these have been agreed through local ICP board. The impact of our broader strategic transformation and recovery plans will need to be incorporated within operational plans.

Estates

By March 2024, our ***estate*** *will be a combined NHS and local government estate, comprised of rationalised and consolidated estate operated on purchasing and leasing arrangements to create a 'One Public Estate' at scale with local control.*

Our vision is to place assets at the heart of the community. It will be an integrated estate which allows all our public partners to serve citizens across Surrey Heartlands. We aim to effectively use assets from NHS, County Council, District Councils, Fire, Police and the third sector to support our integrated services. We have already begun a programme of estates transformation which looks to harness the financial resources of the County to create a "one public estate" across Surrey.

To support this integration, we are seeking to appoint a Joint Estates Director across Local Authority and the NHS during 2020.

The estates programme supports the Surrey Heartlands ICP priorities of improving care for people with mental health conditions, and enabling children, young people, adults and elderly people with mental health issues to access the right help and resources. It also supports the Long Term Plan priority of better care for Adult Mental Health.

The programme also promotes better use of assets and capital receipts from disposals, co-location of community services to improve joined-up care, avoidance of backlog maintenance, lease costs on other premises and facilities management cost, and allows better phasing of the inpatient mental health refurbishment programme.

To support Local Authority and NHS integration, we are seeking to appoint a Joint Estates Director during 2020.

We will continue to accomplish this by:

- Investing Systematically and on a prioritised basis to improve and reconfigure our care settings, ***which will***
- Create a System-wide network of integrated care centres in accessible community locations, ***which will***
- Support the bringing together of multi-disciplined teams of health and care professionals, ***which will***
- Improve the efficiency, effectiveness and sustainability of local care services for everyone

The table right shows a summary of the programme of work we have planned over the next 5 years and read how the estates programme enables the 'Outpatient transformation' in the section '*the need for radical change*'.

You can find out more about our planned work in our **Estate Strategy** (appendix 14).

Capital Plans	Strategies
Community Hubs Programme	

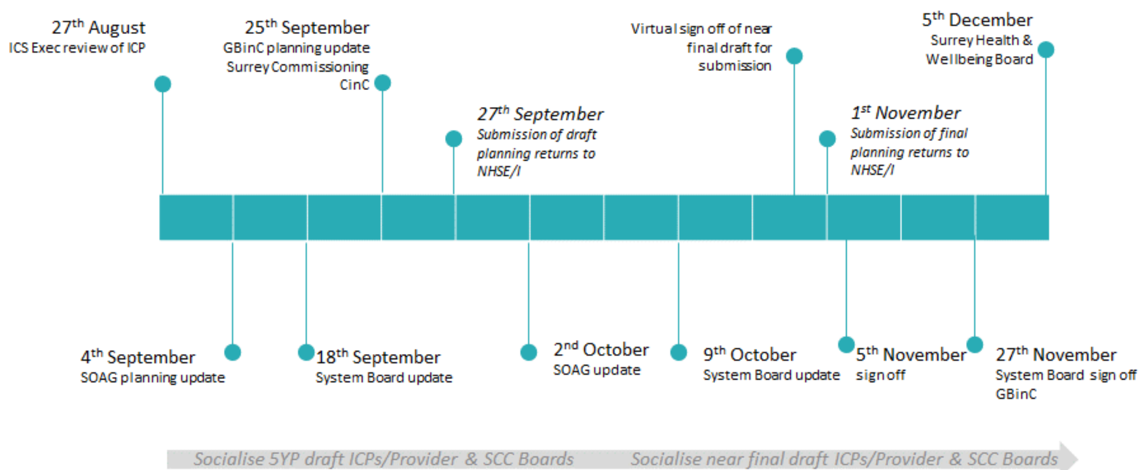
Capital Plans	Strategies
Places of Safety for mental health crisis in Guildford and Chertsey	supports the Surrey Heartlands ICP priorities of improving care for people with mental health conditions, and enabling children, young people, adults and elderly people with mental health issues to access the right help and resources
Refurbishment and reconfiguration of Lavis Suite at RSCH	This project supports the ICS aim to improve the patient pathway for planned care, and the Long Term Plan priority provide better care for major health conditions.
Second Maternity Theatre at RSCH	This initiative is in line with the ICS goal to improve the patient pathway for Women and Children.
Relocate Ashley Practice to new premises	Provide right-size GMS space to Primary Care. A key ICS objective is to ensure our GPs have the necessary accommodation from which to provide their Primary Care services
Redevelopment of St Peter's Hospital site by ASPH	supports the ICS service strategy to strengthen Emergency Care centres and pathways, and aligns with the Long Term Plan priority to reduce pressure on emergency hospital services
The relocation of NEECH services to Epsom General Hospital	Integrated Care Service under the governance of an alliance of health and social care partners builds on the core principles at the heart of Surrey Heartlands Out of Hospital and Primary Care Clinical Strategy
Redevelopment of Molesey Hospital	The Community Hospital Review (2015/16) determined the need to retain Molesey Hospital, and in line with the 5YFV/ GPFV and Out of Hospital strategy, the CCG is developing a sustainable GP/Community Hub to provide improved placed based care to patients
Relocation of Banstead Clinic and GP to Banstead Horseshoe development	The ICS has a target to provide place-based care in fit for purpose facilities. The Banstead Horseshoe project aims to support health systems and Local Authority services from within a town regeneration project
Re-building of Weybridge Hospital/Health Centre	ICS key objective is to re-establish the Health Centre in Weybridge town centre following its total destruction by fire in 2017
Relocate Fort House to Walton Hospital	Provide right-size GMS space to Primary care. A key ICS objective is to ensure our GPs have the necessary space from which to provider their Primary Care services.
Premises improvements to Dorking Medical Practice	
Digital: Community service IT hardware upgrade	This initiative fully aligns with the ICS's Out-Of-Hospital workstream to deliver more direct care in the patient's home and care home settings, and the Long Term Plan priority to boost out of hospital care.
Primary Care Networks	Establishing 24 PCNs, in 4 ICPs (delivering GP Improved Access under the GP Forward View).
Digital: Electronic Patient Records (EPR) investment	These initiatives align with the Long Term Plan priority for digitally enabled care to be made mainstream across the NHS, and meet the requirements for HSLI projects
Working with Local Planning Authorities	This is part of the Surrey Health and Wellbeing Strategy on prevention planning and in the longer term aligns with the Surrey Heartlands' priority of promoting prevention

Capital Plans	Strategies
	to decrease incidences of serious conditions and diseases, and the Long Term Plan priority for more NHS action on prevention.

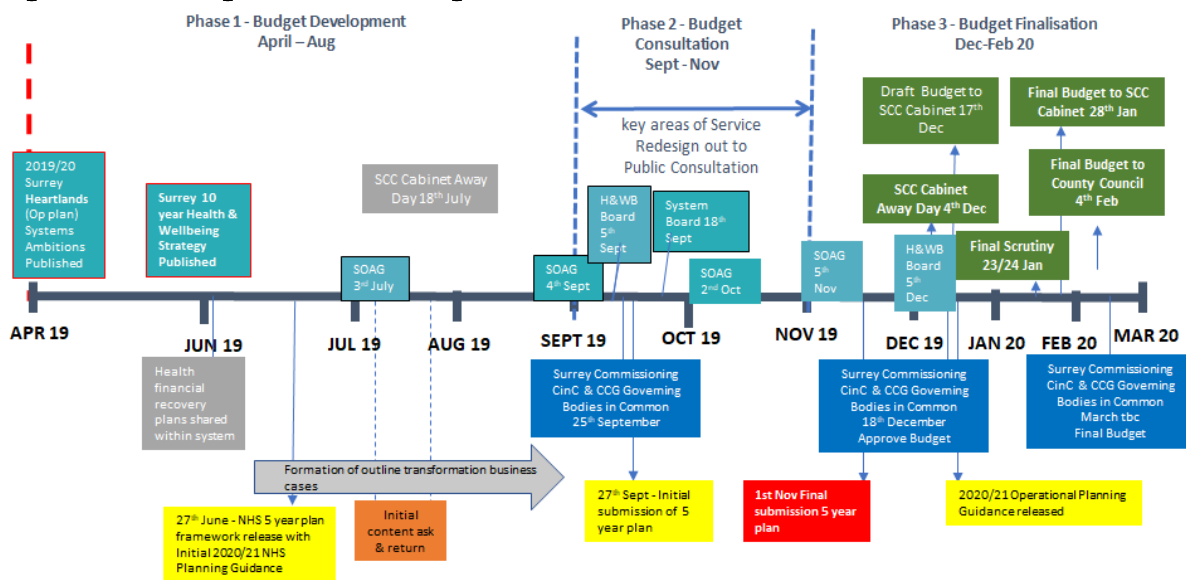
Appendix

1. Approval Timelines
2. Key Planning Assumptions for Finance, Activity and Performance
3. Population Health Management Strategy
4. PHE Proposed Health and Wellbeing Outcomes
5. Surrey Heartlands ICS Strategy
6. Surrey Health and Wellbeing Strategy
7. NHS England (South East) Specialised Commissioning Operating Plan
8. NHSE (South East) Direct Commissioning LTP Delivery Plan
9. Surrey Heartlands ICS Winter Plan V3
10. Maternity Transformation Plan
11. Surrey & Sussex Cancer Alliance Strategy and Annex
12. Mental Health LTP Ambitions Tool
13. Workforce Delivery Plan
14. Estates Strategy
15. Needs assessment for General Dental Services in Kent, Surrey and Sussex
16. Surrey Heartlands Digital Strategy (update)
17. Glossary

Appendix 1 – *Approvals Timeline 2019*



High Level Integrated Planning Timeline



Appendix 17 – Glossary

Acronym	Description	Acronym	Description	Acronym	Description
3Cs	Children in Care Service	CDOP	Child Death Overview Process	ECHO	Extension for Community Care
5YFV	Five Year Forward View	CETR	Care, Education And Treatment Reviews	ED	Emergency Department
A&E	Accident & Emergency	CGM	Continuous Glucose Monitoring	EDI	Equality, Diversity and Inclusion
AAC	Accelerated Access Collaborative	CHC	Continuing Health Care	EHCH	Enhanced Health In Care Homes
ACP	Advanced Clinical Practice	CIO	Chief Information Officer	EHCP	Enhanced Health Care Practitioner
ADHD	Attention Deficit Hyperactivity Disorder	CMHT-OP	Community Mental Health Team Outpatient	eHMA	electronic Holistic Needs Assessment
AF	Atrial Fibrillation	CNST	Clinical Negligence Scheme for Trusts	EIIP	Early Intervention in Psychosis
AHP	Allied Health Professions	CO	Carbon Monoxide	ePMA	Electronic Prescribing And Medicines Administration
AHSN	Allied Health Science Network	COPD	Chronic obstructive pulmonary disease	EPR	Electronic Patient Record
AI	Artificial Intelligence	COSD	Cancer Outcome and Services Data	ERS	Electronic Referral Support
ARC	Applied Research Collaborative	CPCS	Community Pharmacy Consultation Service	ES	East Surrey
ASPH	Ashford And St Peters Hospital	CPD	Continuing Professional Development	ESD	Early Supported Discharge
BEN	Behaviour & Neurodevelopment	CPSS	Community Pharmacy Surrey and Sussex	ESHT	Epsom & St Helier Hospitals
BFI	Baby Friendly Initiative	CQUIN	Commissioning For Quality And Innovation	EWMH	Emotional Wellbeing And Mental Health
BI	Business Intelligence	CRHTT	Crisis Response Home Treatment Team	FCP	First Contact Practitioners
BMAE	Black and Minority Ethnic	CriSP	Carer Information and Support Programme	FFT	Friends and Family Test
BME	Black and Minority Ethnic	CSH	Central Surrey Health	FIT120	Faecal Immunochemical Test
BP	Blood Pressure	CSU	Commissioning Support Unit	FRP	Finanical Recovery Plan
BPSD	BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA	CT	Computed Tomography	FTE	Full Time Equivalent
BR+	Birth Rate Plus	CTG	Cardiotocography	G&W	Guildford And Waverley
BSA	Business Support Authority	CTR	Care and Treatment Review	GDS	General Dental Service
C&P	Clinical and Professional	CVD	Cardio Vascular Disease	GI	gastrointestinal
CAG	Clinical Advise & Guidance	CVD-PP	Cardiovascular disease primary prevention	GIRFT	Get It Right First Time
CAMHS	Child And Adolescent Mental Health Services	CYP	Children And Young People	GP	General Practitioner
CBTp	Cognitive Behavioural Therapy for psychosis	D2A	Discharge To Assess	GPFV	General Practice Forward View
CCC	Care Coordination Centre	DES	Directed Enhanced Service	GPIA	General Practice Improved Access
CCG	Clinical Commissioning Group	DNA	Did Not Attend	GPiMH	General Practice Integrated Mental Health (service)
CCIO	Chief Clinical Information Officer	DQIP	Data Quality Improvement Plan	GPSi	General Practitioner with Special Interests
CCQI	College Centre for Quality Improvement	DSPT	The Data Security Protection Toolkit	GW	Guildford And Waverley
CCR	Cancer Care Review	DTOC	Delayed Transfer Of Care	HASU	Hyper Acute Stroke Unit

Acronym	Description	Acronym	Description	Acronym	Description
HDU	High Dependancy Unit	LWAB	Local Workforce Action Board	PHM	Population Health Management
HEE	Health Education England	LWBC	Living with and beyond cancer	PHR	Personal Health Record
HEI	Healthcare Environment Inspectorate	MDT	Multi-Disciplinary Team	PICU	Paediatric Intensive Care Unit
HNA	Holistic Needs Assessment	MEAM	Making Every Adult Matter	PIGF	Placental Growth Factor
HOMS	Heads of Midwifery	MECC	Make Every Contact Count	PMO	Project Management Office
HOPE	Help Overcoming Problems Effectively	MH	Mental Health	POSCU	Paediatric Oncology Shared Care Units
HPV	Human Papilloma Virus	MHSDS	Mental Health Services Data Set	PQN	Perinatal Quality Network
HRD	Human Resource Director	MIU	Minor Injuries Unit	Q&S	Quality and Safety
HSIB	Healthcare Safety Investigation Branch	MSK	Musculoskeletal	QEIA	Quality and Equality Impact Assessment
HTT	home treatment team	MSW	Maternity Support Worker	QI	Quality Improvement
ICP	Integrated Care Partnership	MVP	Medicines Value Programme	QOF	Quality Outcomes Framework
ICS	Integrated Care System	NDA	National Diabetes Audit	QOF	Quality Outcomes Framework
IPS	Individual Placement Support	NDPP	National Diabetes Prevention Programme	QVH	Queen Victoria Hospital
ISDN	Integrated Stroke Delivery Networks	NEWS2	National Early Warning Score	RSCH	Royal Surrey County Hospital
IT	Information Technology	NG12	Suspected Cancer - Referral Guidance Summary (Adult) NICE	RSS	Referral Support Service
ITT	Innovation Technology Tariff	NHS	National Health Service	RTT	Referral To Treatment
ITT/P	Innovation Technology Tariff Payment	NHSE/I	NHS England/Improvements	RUP	Rapid Uptake Products
IUC	Integrated Urgent Care	NICU	Neonatal Intensive Care Unit	SASH	Surrey and Sussex Healthcare NHS Trust
JSNA	Joint Strategic Needs Assessment	NMC	Nursing and Midwifery Council	SAU	Surgical Assessment Unit
KPI	Key Performance Indicator	NND	Neo Natal Deaths	SBL	Saving Babies Lives
KSS	Kent, Surrey And Sussex	NNODN	Neonatal Network Operational Delivery Networks	SBLCB	Saving Babies Lives Care Bundle
LA	Local Authority	NWS	North West Surrey	SCBU	Special Care Baby Unit
LCS	Locally Commissioned Service	OAP	Out of Area Placements	SCC	Surrey County Council
LD	Learning Disabilities	OD	Organisation Development	SD	Surrey Downs
LeDeR	Learning Disabilities Mortality Review Programme	ODN	Operational Delivery Networks	SDEC	Same Day Emergency Care
LHCR	Local Health and Care Record	OOH	Out Of Hours/Out Of Hospital	SE	Structured Education
LMS	Local Maternity Service	PCN	Primary Care Network	SECAMB	South East Coast Ambulance
LOS	Length Of Stay	PHB	Personal Health Budget	SEND	Special Educational Needs And Disability
LTP	Long Term Plan	PHCT	public health commissioning teams	SH	Surrey Heartlands
LVD	Heart Failure	PHE	Public Health England	SHHCP	Surrey Heartlands Health and Care Partnership

Acronym	Description
SIT	screening and immunisation teams
SME	Subject Matter Expert
SMI	Severe Mental Illness
SOAG	System Oversight and Assurance Group
SPA	Single Point of Access
SSCA	Surrey Sussex Cancer Alliance
SSNAP	Sentinel Stroke National Audit Programme
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP-STAMP	Stopping over medication of people with a learning disability, autism or both-Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SyCr	Surrey Care Record
TCAM	Transfer of Care Around Medicines
TIHM	Technology Integrated Health Management
TV	Thames Valley
UCC	Urgent Care Centre
UECMH	Urgent & Emergency Care Mental Health
UTC	Urgent Treatment Centre
VCFS	Voluntary, Community And Faith Sector
VCS	Voluntary & Community Sector
WDH	Wider Determinants Of Health
WTE	Whole Time Equivalent