Appendix 2 – Graphs, tables and pictures

This appendix includes:

1. The graphs, tables and pictures included in the main report, to ensure that they are readable by those not reviewing papers electronically
2. Additional information on returning to pre-COVID levels of service, as referenced in the main report

The information provided in this appendix is presented in the order in which it is referenced in the main report.

Fig 1. Statement of Ambition

Recovery from the COVID-19 pandemic will mean delivering our recovery priorities at the same time as addressing pre-existing requirements on quality of care, operational performance and finance. In some cases there will be a tension between these priorities, e.g. balancing the release of capacity for routine elective care with retaining resilience for future waves of C19.

It is also clear that attempting to return to a pre-COVID 'normal' will fail, the pre-existing challenge in many areas has been multiplied by the effects of the pandemic. A new service model is required to succeed.

Our main effort is to:

- Meet the citizen and patient need caused by the pandemic, including the harm and safety challenges

Which we will achieve by:

- Resetting to a new service model; and
- Achieving financial sustainability

To recover successfully we must take difficult decisions in the interests of our citizens, patients and staff, using our collective resources to improve the outcomes of the population we serve.

We expect this to result in difficult decisions and trade-offs. Programmes, ways of working or other activities which do not contribute to the main effort may stop.

Our recovery must be a system recovery and more than just the sum of organisational recoveries.

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Fig 2. Recovery priorities

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	Meeting citizen and patient need			Addressing new priorities		Reset to a new service model (5)	
	Restoration (3) (4)	Interdependence of health and care (6)	Surge plans (C19 and other)	Hidden harm	Emotional wellbeing (staff and citizen)	Develop (build from)	Transform (re-envisage)
What will we do?*	• Identify and stand up critical services • Quantify diagnostics and elective backlog • Propose ICS-wide approach for key common challenges	• Enhanced home care framework • Home first D2A model, Medically fit for discharge • Care home bed capacity • New model for working with patients OOH and care homes	• Maintain infrastructure for future C19 surges, with new model learning from 1st peak • Planning for non-C19 peaks: urgent care, LTCs, mental health, etc. • Identify at risk services and plan for mitigation • Longer term approach to testing and PPE	• Identify groups at risk from 'hidden' harm or deterioration • Develop and deploy service offer • Resume/step up prevention and screening	• Identify support needs for staff arising from pandemic • Post C19 support for staff and communities	• Capture, catalogue and evaluate learnings and innovations made • Develop, standardise and embed • Rapid re-validation and accelerate existing, value add plans	• Capture and validate citizen and workforce behavioural and expectation shifts. • Accelerate design and delivery priority programmes against clear benefits criteria • Deliver estates (1) strategy and release funding
How will we measure success?*	• Minimised morbidity and mortality from non-C19 causes • Enabler, not a barrier, to new ways of working	• Improved outcomes and experience for those in care settings • Better use of our collective resources	• Resilience to deal with C19 and non-C19 demand • Minimised morbidity and mortality	• Citizens at risk are identified and supported	• Staff and citizens are able to recover from the pandemic and lockdown	• Innovations are retained and generalised • Models of care which deliver better outcomes and citizen experience, sustainably	• Services and support re/designed system-wide in response to citizen experience, need and workforce ambition • Models of care which deliver better outcomes and citizen experience, sustainably

(2) **ICS development & architecture** - System first, Role of ICS, ICPs and PCNs

Social contract with communities - Staff and citizen behaviour change, Comms

(7) **Digital**

*objectives and success measures are indicative and for development

Transformational objectives mapped onto recovery priorities: (1) Generate transformational funds, (2) System first behaviour, (3) Stop, (4) Do it once well, (5) New care models, (6) High cost/poor outcomes, (7) Digital

Workstream leadership

Workstream	CEO lead	Delivery director	Professional lead	Finance lead	Non-exec lead[2]
Restoration	Louise Stead	Helen Coe	Charlotte Canniff & Ed Cetti	Paul Simpson	Fran Davies (CSH)
Interdependence of Health and Care[1]	Simon White & Joanna Killian	Jack Wagstaff	Shelley Head & Sara Barrington	Rakesh Patel	-
Surge planning	Michael Wilson	Helen Coe	Zac Faris	Ross Dunworth	Sue Sjuve (RSCH) Mark Byrne (CCG)
Equalities and Health Inequalities (formerly Hidden harm)	Ruth Hutchinson	Trudy Mills	Russell Hills & David Fluck	Daniel Peattie	Gill Edelman (CCG) & Caroline Shuldham (CSH)
Emotional wellbeing	Fiona Edwards	Helen Rostill	Justin Wilson & Sue Denton	Graham Wareham	Pauline Lambert (SASH)
Develop and Transform	Steve Flanagan	Tom Smerdon and Helen Coe	Mark Hamilton	Graham Wareham and Karen McDowell	Andrew Prince (RSCH) & Caroline Warner (SASH)
ICS Development & architecture	Claire Fuller	Karen McDowell	Charlotte Canniff	Karen McDowell & Ross Dunworth	Jonathan Perkins (CCG) Peter Collis (ICS) Brian Ingelby (First Community) David Sadler (SASH)
Digital	Fiona Edwards	Katherine Church	Andy Sharpe	Simon Marshall	Rahul Jaitly (SaBP) John Machin (CSH)

[1] Workstream closed [2] Non-execs are confirmed for the majority of workstreams but roles are to be confirmed for some

Returning to pre-COVID levels of service: Additional information (1/3)

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Electives	Target	90%	100%	100%	100%	100%	100%	100%	100%
	Total outpatient attendances (face to face or virtually)		106%	105%	107%	110%	108%	110%	128%
	Target	25%	25%	25%	25%	25%	25%	25%	25%
	Consultant Led FIRST OP Attendances by phone/video		52%	52%	54%	54%	54%	54%	56%
	Target	60%	60%	60%	60%	60%	60%	60%	60%
	Consultant Led Follow-up Attendances by phone/video		64%	64%	64%	64%	64%	64%	65%
	Target	70%	80%	90%	90%	90%	90%	90%	90%
	Day case Electives		91%	99%	106%	102%	113%	112%	137%
	Ordinary Electives		52%	53%	51%	49%	53%	54%	65%
	Total		81%	90%	90%	91%	97%	96%	116%
	RTT Waiting List		68,542	72,649	74,182	75,990	77,372	78,358	77,528
	52 Week Waits		781	714	662	597	615	554	332
Diagnostics	Target	90%	90%	100%	100%	100%	100%	100%	100%
	Magnetic Resonance Imaging (MRI)		90%	100%	100%	100%	100%	100%	100%
	Computed Tomography (CT)		90%	100%	100%	100%	100%	100%	100%
	Colonoscopy		96%	95%	106%	98%	104%	91%	123%
	Flexi Sigmoidoscopy		80%	85%	103%	97%	93%	98%	116%
	Gastroscopy		99%	96%	103%	93%	116%	106%	138%

Paras 15 and 16 of the main report discuss key aspects of our plan to return to pre-COVID levels of service, as agreed with our regulators NHS England and NHS Improvement (NHSE/I).

This section of the appendix provides further information on that plan, which was agreed with NHSE/I in September 2020.

This table reflects the targets set by NHSE/I and how our Surrey Heartlands plan responded to them. The measures used by NHSE/I and our plans are explained on the subsequent slides.

It is important to note that, at the request of NHSE/I, these plans are prepared on the basis of 'best possible' efforts. Therefore, subsequent COVID waves and winter pressures were a clear and acknowledged downside risk, although mitigations are in place.

Validated actual data for the period and measures shown is very limited and is not shown here. This table illustrates our plan only.

However, early data suggests that we are successfully delivering planned levels of activity across the majority of services and delivering 25% more endoscopies than before COVID.

Returning to pre-COVID levels of service: Additional information (2/3)

Total outpatients attendances

- This measures the total number of outpatients attendances compared to the previous year. This is expressed as a percentage last year's number. So '110%' means we plan to conduct 10% more outpatient appointments than we did pre-COVID.
- We plan to exceed 100% of pre-COVID levels in every month from September 2020 to March 2021, above the national target of 100% in that period.

Consultant led outpatient (OP) appointment attendances by phone or video

- There are two separate measures, one for first time appointments and one for follow ups.
- Both measures consider the proportion of appointments which are conducted remotely rather than face to face. So '60%' means 6 out of 10 appointments are remote and the remaining 4 out of ten are face-to-face.
- We plan to deliver over 50% of first time and over 60% of follow up appointments remotely, exceeding the national targets of 25% and 60%, respectively.

Day case and 'ordinary' electives

- There are two separate measures, one for day case elective procedures and one for other 'ordinary' elective procedures.
- Both measures consider the total number of procedures undertaken compared to the previous year. This is expressed as a percentage of last year's number. So '110%' means we plan to conduct 10% more procedures than we did pre-COVID.
- Although day cases and 'ordinarys' are planned for separately, the national target is a blended measure for total procedures. This is not a straight average of the two due to higher numbers of day case procedures.
- We plan to deliver over 99% of pre-COVID day case procedures in October and over 100% from November onwards. Our plan for Ordinary electives is lower due to the higher impact of COVID restrictions such as social distancing between beds.
- Overall, we planned to deliver an increasing proportion of pre-COVID activity and exceed the national target of 80% in September and 90% for the remaining period until March 2021. However, the impact of the second COVID wave is expected to have a significant impact on these plans.

Returning to pre-COVID levels of service: Additional information (3/3)

Waiting list

- There are two separate measures, one for the total number of patients waiting for treatment following referral and one for the number of patients who have been waiting longer than 52 weeks.
- The increase in the waiting list size reflects increasing referrals as patients and citizens return to referring services.
- There are no national targets for either waiting list measure, however our ambition is to reduce long waiters to zero as soon as possible. A national comparison shows that Surrey Heartlands patients, overall, are waiting for less time than the national and regional average.
- The planned decrease in long waiters reflects the focus on reducing long waits, however this has been an area of challenge and early data indicates we have not managed to reduce the number of long waiting patients in the manner we have planned. However, patients continue to be treated in order of clinical priority and, unless patients have chosen to defer treatment, remaining patients on the list of long waiters are those with benign conditions. Treating all long waiting patients continues to be a priority moving forwards.

Diagnostics

- There are several measures, each comparing the number of procedures undertaken for a different diagnostics test. This is expressed as a percentage last year's number. So '110%' means we plan to conduct 10% more procedures appointments than we did pre-COVID.
- There is a national target for the combined CT and MRI procedures performed and no target for endoscopies (colonoscopy, flexi-sigmoidoscopies and gastroscopies). We planned to deliver 100% of pre-COVID levels for both CT and MRI from October, meeting the national target. We also planned to reach 100% of pre-COVID levels for endoscopies by November and maintain approximately these levels for the rest of the period.
- We have been successful in delivering an increase in diagnostics capacity, reaching 125% of pre-COVID levels at the time of writing despite the significant challenges presented by COVID considerations such as infection prevention and control procedures.

Figs. 3 and 4

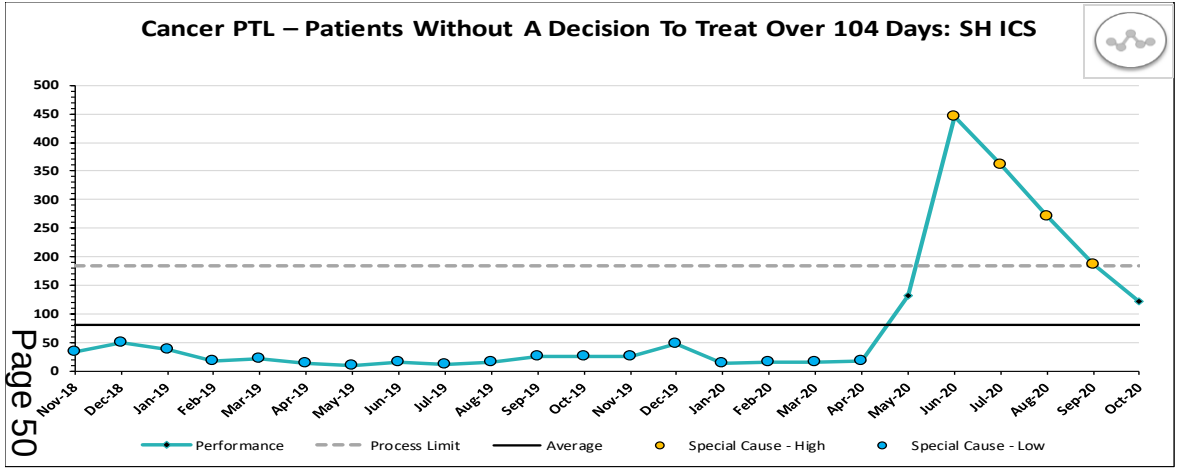

Fig 3: Cancer waiting list

Fig 4: Percentage of patients waiting longer than 6 weeks for Diagnostics

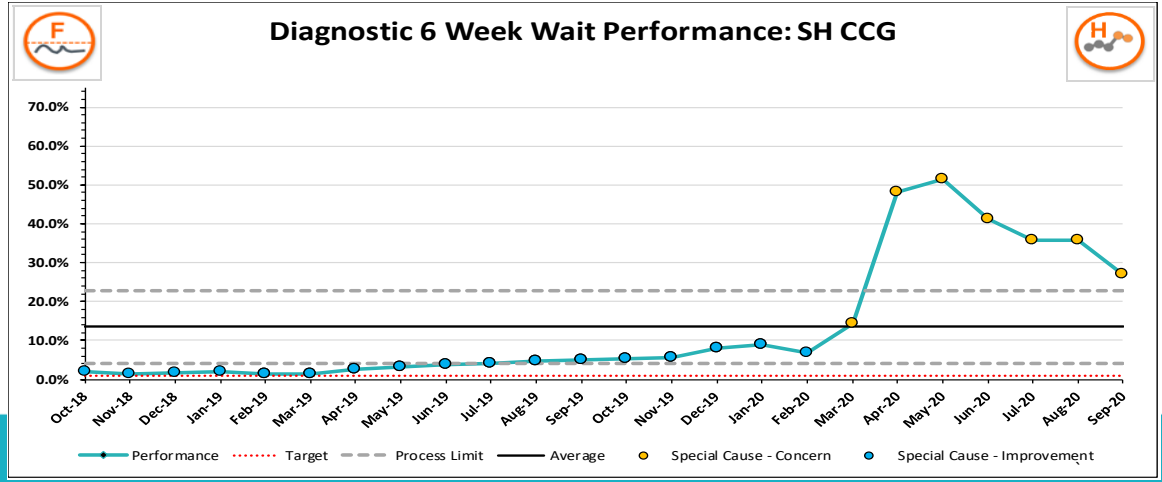

Fig. 5

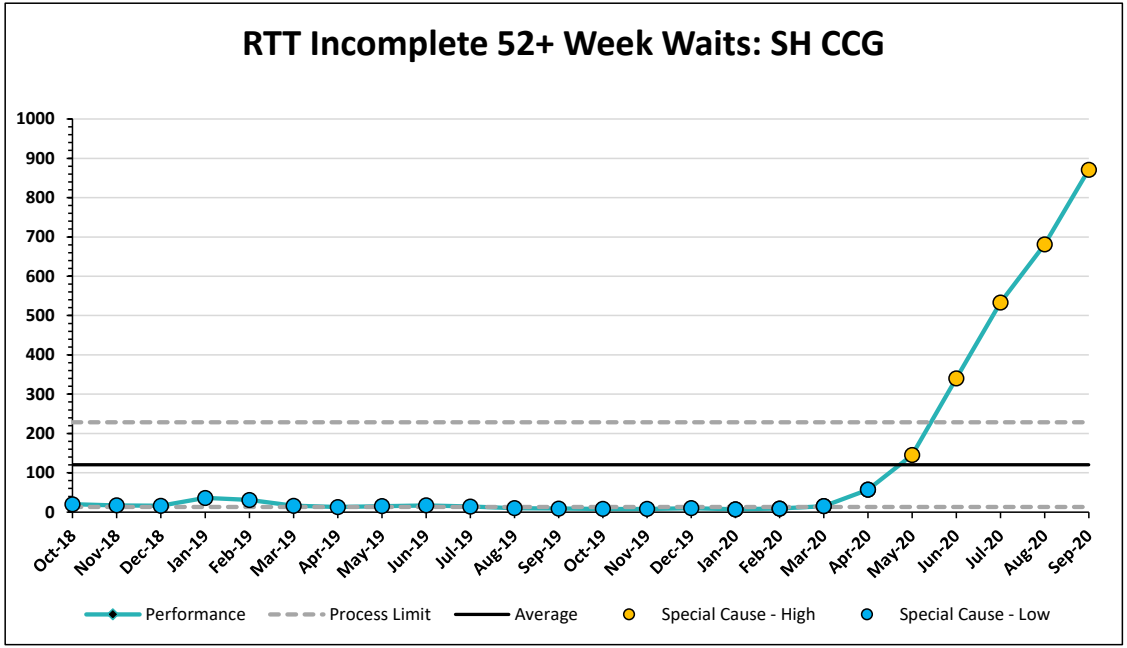

Fig 5: Number of patients waiting longer than 52 weeks for treatment

Fig. 6

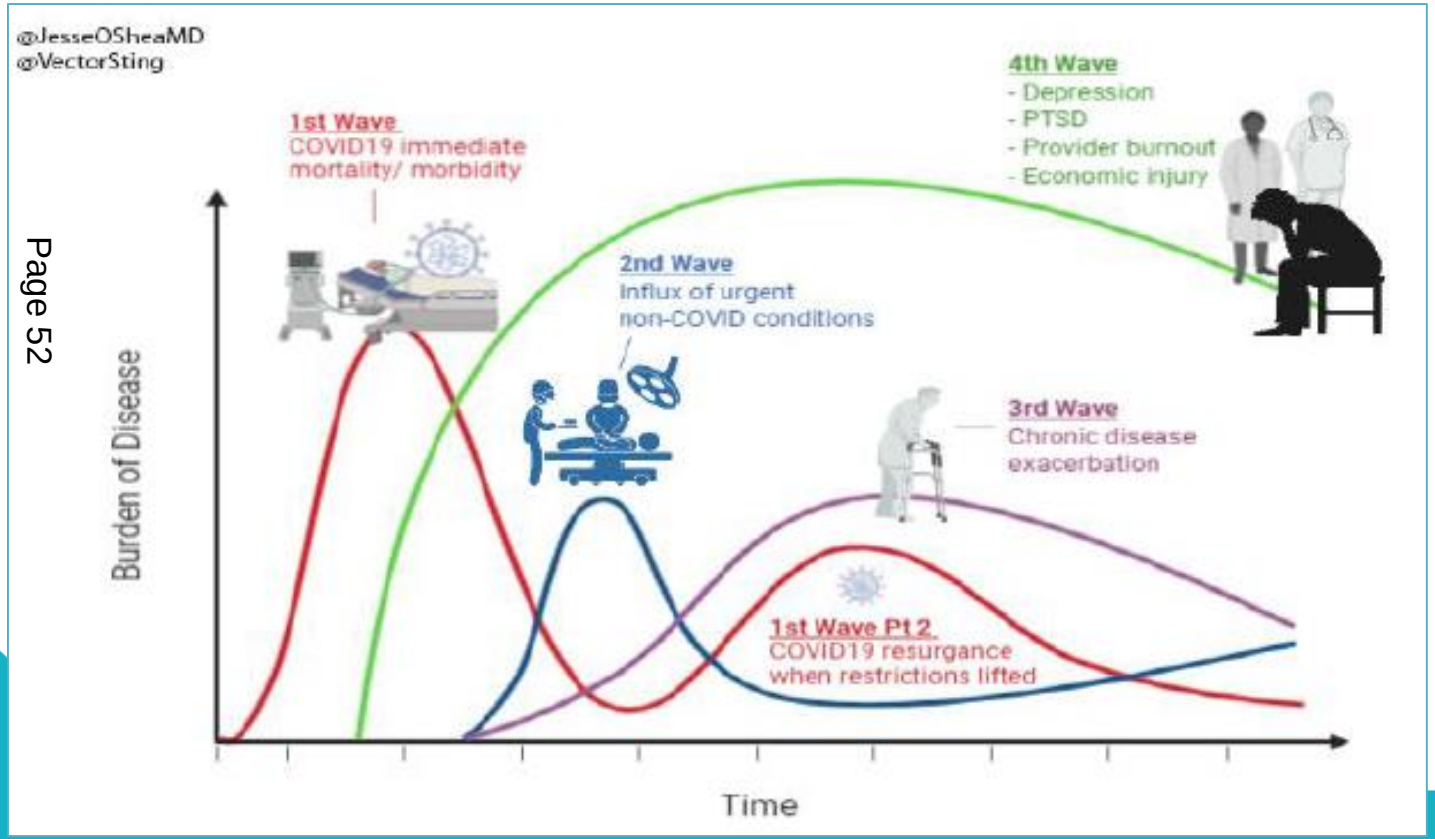

Fig 6: Illustration of the progression of the burden of disease

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Fig. 7

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Changing how we worked – a rapid shift to digital

Accelerating roll out of our Surrey Care Record to join up care during our Covid response - 90% of GPs engaged and sharing data, along with adult social care, mental health and acute trusts.

Virtual Safe Havens enabling services to continue in lockdown

Virtual mental health assessments to ensure access to vital services for vulnerable people

Launched virtual consultations across all community and acute services, including mental health and social care.

Shifted talking therapy services to digital with therapy and bereavement support

Creative use of social media to promote the support available

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Fig. 8

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Next steps on Digital inclusion

1. **Continue our engagement work to gain greater insight** and understanding of digital exclusion
2. **Develop system-wide outcomes for inclusion**, addressing the factors already identified
3. **Digital inclusion to be owned by the ICS Executive** (linked to health inequalities), with ambitious targets around improving participation, digital access and embedding inclusion
4. **Work on our digital infrastructure**, achieving faster broadband to get more people online
5. **Review our digital, engagement and broader strategies** to ensure digital inclusion is considered (and plans for a new NHS Digital Health Technology Standard)
6. **Build digital inclusion into the design of all our projects** and into procurement criteria
7. **Build digital inclusion criteria into our governance for all projects** that have a digital element
8. **Create a cross Surrey Heartlands digital champions programme** across health, the voluntary sector and the council to create a digital training programme for people who want support

Fig. 9 Population Intervention Triangle

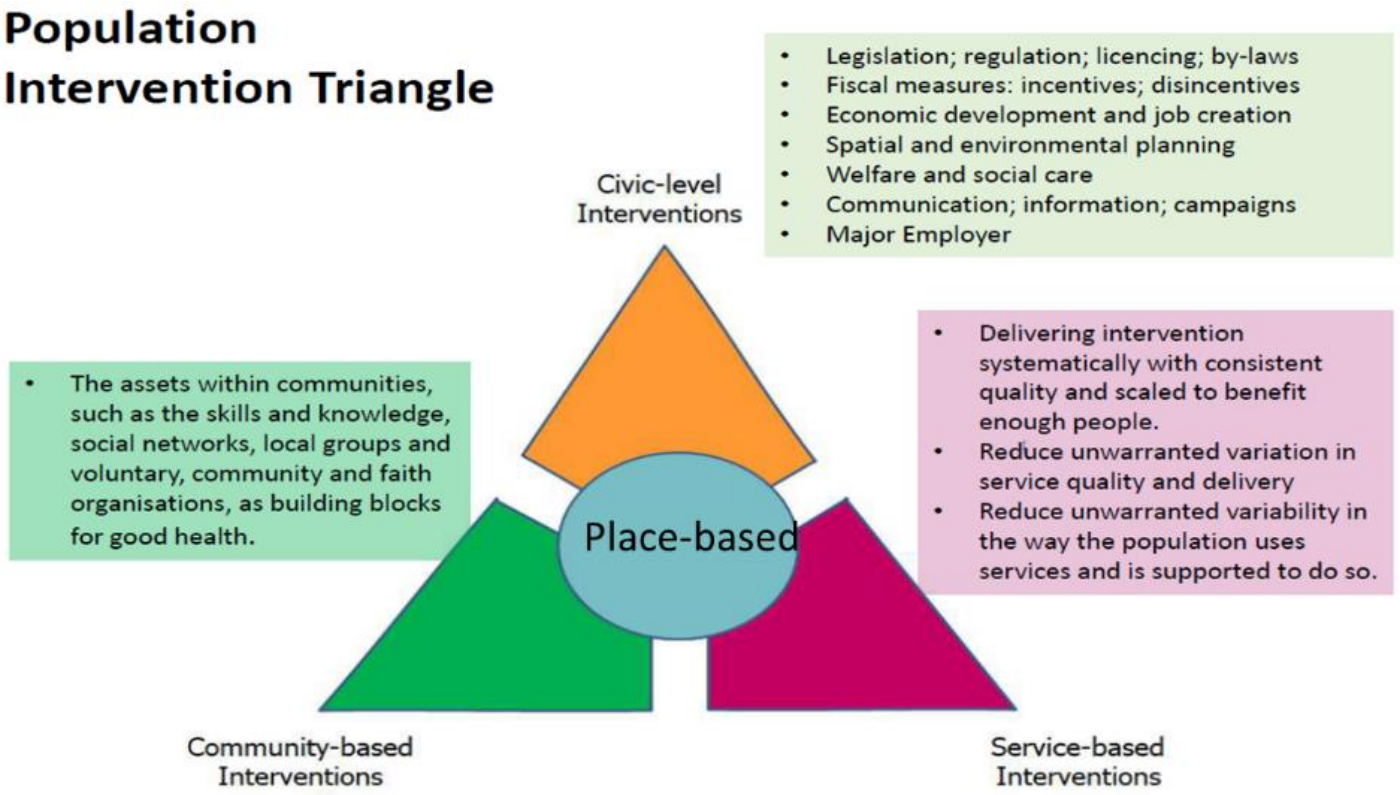

Fig. 10: What is the CIA?

	Product	Description
	**Geographical impact assessment**	Presents analysis of the impact of Covid-19 on local communities across health, economic and vulnerability dimensions. The analysis helps to **identify which places in Surrey have been most affected** by the pandemic and how.
	**Local recovery index**	The LRI is a **surveillance tool for monitoring how well Surrey is recovering from the pandemic.** It looks at a range of indicators across three themes; Economy, Health and Society.
	**Temperature check survey**	**Survey of over 2,000 households** from across Surrey to understand their experiences of the pandemic and lockdown.
	**Community rapid needs assessments**	**10 in-depth assessments of how vulnerable communities have been affected during Covid-19** and these communities' needs and priorities.
	**Place based ethnographic research**	Detailed research to understand the **financial, emotional and community impacts of Covid-19 on individuals living in communities that have been most impacted.**

Fig.11: Addressing health inequalities

Disproportionate effect of Covid-19 on BAME communities

The system has taken a proactive and collaborative robust response, with key actions including:

- Rapid Needs Assessment with Public Health - high risk colleagues removed from frontline, safety guidance and equipment issued to at risk staff, extended risk assessment to primary care and care homes.
- Identifying additional clinical services that can provide support to at risk BAME groups
- Survey on impact of Covid on BAME communities by Independent Mental Health Network /Surrey Minority Ethnicity Forum
- Bespoke comms on testing for BAME communities
- Peer to peer engagement and support events
- Bespoke guidance for independent care sector

Surrey Heartlands **BAME Alliance** set up to:

- Support and protect BAME colleagues through Covid-19 and improve WRES data outcomes and overall working experience in Surrey Heartlands
- Provide support and protection for BAME communities and reduce health inequalities

The recently established 'Turning the Tide' group also links into our Equalities and Health Inequalities workstream.

Staff Risk Assessments

As part of our response, the system came together in a workforce steering group to support risk assessment completion

- Steering group worked collaboratively to develop risk assessment tool
- All NHS providers submitted information to NHSE SE regional checkpoints
- At the 2nd September checkpoint, 5 out of 7 organisations had completed 100% of risk assessments on BAME staff and the remaining two 99%
- Risk assessment guidance and documentation developed for independent sector and distribution to over 640 care settings
- Primary care made significant progress in collecting ethnicity data and completing risk assessment
- ICS leads working with NHSE regional/national leads to support completion

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