One System, One Plan

Prof Claire Fuller - CEO

Dr Pramit Patel - Partner Member for Primary Care Services

One System, One Plan

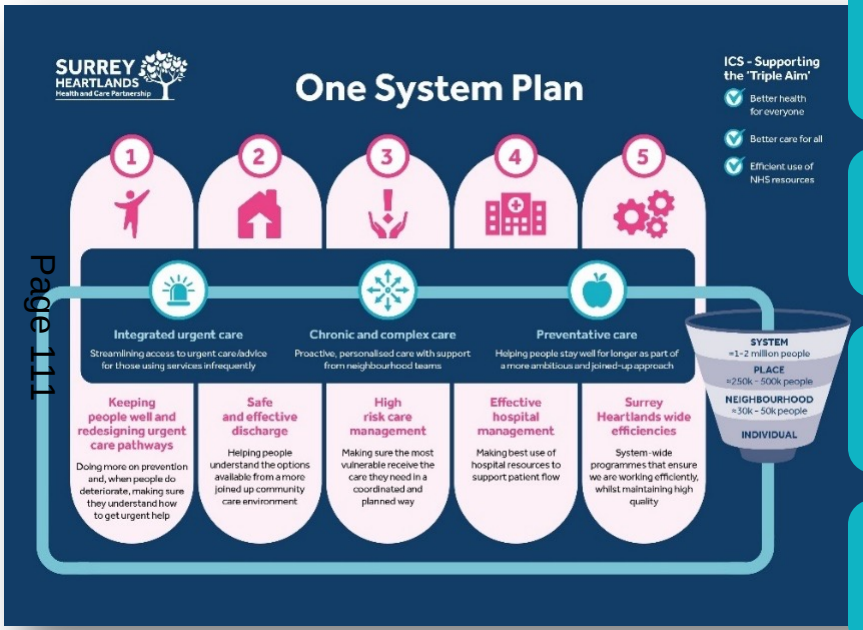
The purpose of this document is to support health and care leaders and teams right across Surrey Heartlands to understand and embrace the opportunities our new way of working presents.

It sets out how we are creating the conditions to break down many of the organisational barriers that have previously got in the way of health and care organisations delivering their services optimally to best meet the needs of our patients.

At the heart of the document is how we are aligning everything we do in health and care to achieve two keys aims:

- **Making it easier for patients to access the care that they need when they need it, and**
- **Creating the space and time for our clinicians to provide the continuity of care that is so important to our patients.**

Anchoring transformation around our neighbourhoods



Health and care organisations – **supported by the voluntary sector and driven by local Place Committees** – will deliver against these objectives by providing more services through Integrated Neighbourhood and Place Teams

Integrated Neighbourhood 'Teams of Teams', will evolve from existing Primary Care Networks which will work collaboratively to improve the health and wellbeing of the local population.

Wrapping integrated neighbourhood teams around our practices will enable them to deliver the majority of care to the population, providing long term continuity and cradle-to-grave care wherever possible.

Creating the system conditions to **enable our four Place-based partnerships or Alliances** to transform the way family doctors and other health and care professionals offer care locally as *Primary Care Networks* transition into locally-designed Integrated Neighbourhood Teams.

Shaping our approach with our communities

Building together

Engaged to build our approach & plan

- In depth qualitative research into access to General Practice
- Citizen panel surveys and qualitative research
- Talked to people in their communities
- Engaging with health and primary care teams, e.g. Guildford
- Covid-19 Community Impact Assessment

Innovating locally

Enabled local exemplars

- ***Growing Health Together*** in East Surrey
- ***Guildford & Waverley Alliance*** appreciative enquiry approach
- **Equity Development Officers** in East Surrey
- Working with **Citizens Advice** to better understand financial challenges in our communities
- **Social prescribing** in some of our communities

Hard-wiring this approach by supporting Places to:

1. Develop and launch full partnership engagement programmes in next 12 months
2. Deliver more community projects supporting local well-being and prevention
3. Share learning and best practices for people involved in community development and health creation

How the new model works – neighbourhood teams

1. **Creating a clear ‘Inbound’ and ‘Outbound’ model**

   Inbound - our Team of Teams streamlining urgent care same-day access delivered by a multi-disciplinary teams
   Outbound - The additional capacity releases time for GP practices to streamline things like medication reviews for patients with long term conditions and help patients avoid unnecessary appointments elsewhere in the health

2. **Rolling out cloud-based technology across our system**

   Enabling the seamless flow and re-direction of patients : offering ‘call-back’ functions to enhance patient experience, the ability to audit clinical encounters, and enables patient data to be easily accessible to aid clinical decision making.

3. **Improving demand and capacity responsiveness in primary care**

   A daily feed, directly from the clinical systems, allows us to see in near real-time any rising pressure, which can trigger an automated alert to the local teams who then respond by providing additional support to individual practices.

4. **Improving planned care**

   Integrated Neighbourhood Teams will be supported by a Complex Care Function operating right across Surrey Heartlands, bringing together hospital specialists, specialist therapies, diagnostic infrastructure and our virtual ward provision to deliver an improved Complex Care Function which will have significant impact on releasing capacity elsewhere in the system.

5. **Creating the physical space for our Team of Teams**

   Reimagining how we use Primary Care buildings to create a positive working environment for staff and be a catalyst to integration and to focus on patient needs when thinking about how we use our buildings in the future.

How the new model works – integrated same-day urgent care

Our approach

Developing effective, resilient, neighbourhood-based same-day access to urgent care that can serve as an easily-accessible first point of contact for patients with routine issues.

- Excellent triage
- Appropriate clinicians
- Patient experience and satisfaction
- Quality of care
- Overcoming local barriers
- Staffing

Leading to…

Enhanced Access Hubs – same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends;

Urgent Community Response - for our more complex and frail patients we will provide an MDT rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital;

Community Diagnostic Hubs – working across Place we have developed models of diagnostics that are placed within local communities, including outreach models such as working with the homeless communities who can now access mobile Hep C screening and liver testing as well as Covid Vaccination from an outreach Community Team;

Care Homes – we have implemented an MDT approach to the management of care for these residents, particularly those who are more complex requiring extra support to avoid hospital admission;

Frailty Models of Care - we have developed key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely.

Anticipatory Care Models – using our new digital risk stratification we can better target those most at risk of admission and attendance into the Urgent Care system

Creating the right space for our Teams of Teams

Finding the physical spaces for our teams to co-locate and work together to improve care is one of our main challenges

We have a dedicated team working across Surrey to identify joint opportunities around using buildings that could support the future integration of services. They are:

Baselining the whole estate – to understand the value, costs and condition of every building currently used for health, including the primary care (GP) estate;

Developing new Investment principles – to enable us to both prioritise investment and find new opportunities to develop estate;

Identifying opportunities to potentially consolidate existing sites to deliver wider objectives, for example, releasing value to support reducing system inequalities;

Developing a Blueprint Framework for the governance and delivery of multi-partner place-based projects.

Enabling us to:

1. Move to an approach that make **estates a catalyst to integration**
2. **Focus on patient needs** when thinking about how we use our buildings in the future
3. **Understand and explore the potential for new opportunities**, especially around the use of commercial estate
4. **Create a positive working environment for staff** -including adequate space for activities like training and teamwork.

Building expertise, developing talent & transforming recruitment

Modernising and integrating recruitment	By integrating recruitment across a range of partners we can help attract and share candidates across settings, ultimately ensuring individuals can benefit from access to multiple opportunities without having to complete multiple applications
Building new capabilities	The **Surrey Heartlands Health & Social Care Academy** will help to build, develop, share, and nurture talent across all settings. Using rotational programmes for students and other roles, we will augment the exposure to primary care, community health and social care settings to help attract and retain talent.
Developing fulfilling careers	Expanding Additional Roles Reimbursement Scheme in primary care and integrating workforce activities with social care will help enhance career opportunities in community settings. We're also trialing a Career Guarantee - offering two jobs at the same time in some career pathways – an initial role and a conditional offer for the next role
Establishing a 'Surrey Offer'	Teams of Teams will be more effective if we work toward ensuring equity of opportunity, access to support and experience – closing the disparity that currently exists. Also prioritising how access to things like affordable accommodation and financial well-being services can be accessed by all staff.
Supporting Learning and Development	The Health and Care Professional Leadership Framework will support leaders from across health and care through a 'system leadership' support offer, access to leadership academy programmes and profession-specific leadership development.

Transforming digital infrastructure and data to accelerate change

Our data integration and warehousing programme is helping create the platform for a **central data and analytics ecosystem** built on using of shared data across a range of partner organisations across Surrey including health, local authority, police and third sector

Already integrated all our major providers on the **Surrey Care Record**

Successfully rolled out remote monitoring and virtual ward platforms across the system

General practice is promoting the NHS App and NHS.UK to reach **60% adult registration by March**

Linking the Surrey Care Record to our Population Health Management platform will improve segmentation and give us the knowledge and information to enhance direct care of patient cohorts and support personalised, anticipatory preventative care, leading to:

An **Integrated Data & Digital Platform**	**A System Intelligence Function**	**A Population Health Hub**
Initially focused on developing a population health-based approach to health and wellbeing	To support place & neighbourhood teams to use our Integrated Data Platform to improve our predictive capability to support planning	To work with the wider system to promote, sustain and spread successful interventions and innovations

Making our approach sustainable

1. **Governance & decision making**

Decision making as local as possible, with the broader system leading on accountability and ensuring improvement, innovation, investment and support is targeted where it will have the greatest impact on patients and communities

2. **Quality Improvement**

Committed to continuous care quality improvement at every level of our system and have established the **Quality Improvement Collaborative** to drive our quality governance model across Place-Based areas and ICS. The Health and Care Professional Committee providing system-wide leadership across the spectrum of the quality agenda

3. **Supporting practice sustainability**

Undergoing a series of access visits to understand pressures and challenges that may be faced by General Practice to determine what additional support and improvements that may be made

How will we know when we are succeeding?

Access

Continuity

Reducing inequality

When every patient is able to access primary care easily, efficiently and receive the appointment type of their choosing

When we see an increase in personalised care being provided by multi-agency, multi-disciplinary teams with care co-ordinators: enabling patients to see the same clinicians or teams. We should also see a reduction in the number of ED attendances for defined cohorts of patients, an overall reduction in the number of GP contacts and a reduction in the number of outpatient contacts

When we see cohorts of patients being identified where there is clear inequality in terms of life expectancy, immunisation and screening, diabetes, cardiovascular prevention and early cancer diagnosis in populations who aren't routine health seekers: all of whom need to be able to be supported to have the care they need. Identifying and supporting these patients will also help to see a measurable impact in addressing the C20+5 gap

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