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1.0 FOREWORD

1.1 Last year we reflected on the significant achievements we had made during the first 12 months since the authorisation of the CCG. We also highlighted the major challenges we were addressing to continually improve the quality of care and enable the population of Guildford and Waverley to live longer and healthier lives.

1.2 In 2014/15 we published our 5 year Strategic Plan and our 2 year Operational Plan. These demonstrated our commitment to meet these challenges. This Operational Plan for 2015/16 draws on our previous work and describes how we are focussed on our key objectives and the plans and initiatives that will enable us to meet them.

1.3 We will continue to learn and understand what changes are needed based on discussions with the public, patients, member practices, staff and local health and social care organisations, and what changes are most effective based on national and local evidence. We will continue to work closely with local organisations at strategic and operational levels, whilst recognising the importance of individual conversations that take place every day with our stakeholders.

1.4 The shift towards the integrated multi-speciality community provider model is the first step to a more joined up health and social care service. We know that achieving the integration of services at all levels is critical to developing a truly sustainable NHS and social care system.

1.5 The provision of timely, appropriate urgent care remains a critical aim. We are increasingly aware of the importance of good discharges and are developing and implementing the acute clinic model, which allows more patients to go home the same day with an electronic discharge summary setting clear diagnosis and treatment plan. In partnership with Surrey County Council the Better Care Fund will integrate the discharge process and ensure adequate community based support services are available to support patients to recover out of hospital where appropriate.

1.6 Within the organisation we have the clinical drive and have spent much time building relationships, and moving the commissioner-provider relationship to a place that will allow real scale change at a level that would be impossible through traditional linear contracting. Our frailty working has been highlighted nationally and our in-reach GPs are an innovation that will imminently deliver. The Referral Support Service will lever the support of our GP Membership and enable the implementation of the planned care programme.

1.7 This Operational Plan sets out the next steps on this challenging journey. The experiences we gain will help to inform long term strategic planning, with our local partners, for the benefit of the population of Guildford and Waverley. Our plans must ensure that we improve health through prevention and offer the best proactive treatment for all our patients. It will enable us to support patients and carers through physical and mental illness and allow more people to live full and independent lives.
2.0 EXECUTIVE SUMMARY

2.1 Our Plan is based upon the 5 year Strategic Plan, published 2014/15, the Surrey Health and Well Being Strategy, and the three main NHS providers operational strategies. Our understanding of the health needs of our population is derived from discussion and consultation with local people, local providers and other stakeholders and through working in close partnership with local authorities and public health.

2.2 The challenge facing our local health and social care system over the next few years is considerable. The creation of the Better Care Fund has further crystallised the need to work jointly across the health and social care system. We need to drive widespread, transformational change across the local health and social care economy with a continual focus on the quality and safety of services and achieve improvements in the experience for patients, while enabling the whole system to remain financially viable.

2.3 Surrey’s population is growing and will continue to increase over the next few years. Surrey has an ageing population: 19% of the population is aged 65+ and this is expected to increase by 10% over the next 5 years.

2.4 In order to effectively transform the whole system in line with the clear direction set out in the Five Year Forward View, the Commissioning Intentions 2015/16 seek to commission services that improve access for individuals to Primary Care and non-hospital based services and Mental Health and Learning Disability services. We are committed to ensuring that individuals, who are nearing the end of their life, can choose where they receive their care and die, and to improving the provision of health services within care and nursing homes.

2.5 An imperative in fulfilling our vision is to achieve financial sustainability. If we can deliver that vision of integrated health and social care services, we will deliver a high quality, sustainable NHS in future years. To achieve this we need to shift resources from the acute sector to the primary care sector.

2.6 The Quality, Innovation, Productivity and Prevention (QIPP) programme was set up by the Department of Health to improve care and lower costs in the NHS. Our intended Service Transformation efficiencies of £15.2m (6.3%), in addition to provider efficiencies over the next year, will seek to create a sustainable NHS in line with the ‘Call to Action’.

2.7 Our strategic direction of travel and many of our operational initiatives will have significant implications for our providers. To succeed we will need to work through, understand and sensitively manage these challenges.

2.8 The draft financial plan for 2015/16 shows that the CCG is planning to deliver a breakeven position, which does not meet the national business rules of delivering a 1% planned surplus. In addition, the CCG is planning to fund a 1% non-recurrent strategic investment reserve and a 0.5% contingency reserve, in accordance with the planning requirements, and the repayment of the financial support to Surrey CCGs in 2015/16.
2.9 In order to deliver the significant financial efficiency target, a number of programmes have been established, with a Governing Body GP clinical lead and management staff who work with stakeholders, including patients, their families and carers to understand and design effective streamlined services that deliver quantifiable benefits.

2.10 Our Planned Care Programme did not deliver at the pace required in 2014/15, despite the level of clinical engagement, but mobilised initiatives that will impact in 2015/16. We will see rapid and full delivery during 2015/16 in a number of specific clinical areas including; Cardiology (nurse led pathways and triage), Ophthalmology (Optometrist delivered acute eye care and glaucoma surveillance) and MSK medicine (Extended Scope Physiotherapist (ESP) triage and unified pathways). However our broader programme will address Out Patient appointment activity globally, with the primary outcome being a whole pathway rationalisation of follow-up activity across disease areas. Follow-ups will be minimised with existing activity converted to either “If needed only”, “Remote/Virtual follow-up” or “formalised GP follow-up”. We expect to see a reduction in follow-up activity of 20% achieved by end of year. This programme has the potential to deliver a saving of £6.2M.

2.11 Our Unplanned Care Programme was a huge success in 2014-15, with our performance as a local health economy in the upper quartile nationally. Our main provider achieved the 95% A&E access target with our assistance – we provided intense project management support, clinical engagement and a successful publicity campaign. Our length of stay in over 65 year old unscheduled care dropped by a day in 2014-15, against the national trend. Our care home unscheduled admissions continue to fall. We expect this performance to intensify and deliver increased savings in 2015-16 as our clinical work embeds – not only through the above workstreams, but with our new Integrated Care Partnership delivering anticipatory care in the community to avoid unplanned admission. As this work develops in 2015-16 we expect to see an in-year saving of £5M.

2.12 Mental Health and Learning Disability programmes seek to improve access to appropriate services, recognising the inequalities of health outcomes that exist in these patient groups. A range of schemes will work towards increasing access to both mental and physical health services, working to improve screening rates and ensuring that assessment, diagnosis and treatment is delivered to the patient in a timely manner.

2.13 The Better Care Fund Local Joint Commissioning Committee has agreed a Section 75 partnership agreement for 2015/16 between Surrey County Council and G&WCCG and a target 1% reduction in non-elective admissions. This provides the forum where integrated commissioning will influence integrated provision, seeking to ensure that duplication is minimised and that proactive care reduces demands on unplanned and planned services.

2.14 Overall, G&WCCG has demonstrated excellent achievement against the 5 NHS Outcomes Framework core metrics to date. Against the 5 domains/26 performance framework metrics that were published in February 2015, the CCG has only two which are rated as red and needing improvement (‘patient experience of GP out of hours’ and ‘recording the stage of cancer at diagnosis’).
and significant work has already been invested since this was measured to improve the position.

2.15 All service transformation projects are subject to project management processes and documentation in line with NHS IQ best practice.
3.0 INTRODUCTION – FROM STRATEGY TO DELIVERY

3.1 CCG Vision

3.1.1 The CCG is committed to ensuring that innovative, quality driven, cost effective health and social care is in place. We will deliver services which reflect the needs of the local population and improve the health and wellbeing of people living in Guildford and Waverley.

3.1.2 We want our patients and citizens from all parts of our community to experience the following, when needed, as routine:

- A system that integrates health and social care services;
- A system that is focused on the care of individuals;
- A system that recognises and is focused on health outcomes.

3.2 Our Corporate Objectives for 2015/16

- We will improve the health of our local population;
- We will manage the health economy within our available budget;
- We will improve and continually check the quality and safety of patient services;
- We will help GP practices to work together to organise ‘wrap around’ care for the frail elderly, working with local partners;
- We will involve local people in shaping what we do;
- We will be a learning, listening organisation that values our staff and the wider workforce, and supports partnership working;

3.3 Our Local Needs

3.3.1 We have a registered patient population of 219,000 and we must recognise and reflect the characteristics of this population, and the way these are likely to change over time, in our plans for 2015/16 and beyond.

3.3.2 The G&WCCG population profile is weighted towards the older adult population when compared nationally. In addition, the % of the population over 65 will continue to grow over the next 5 years and is anticipated to reach approximately 20% by 2020 (with c.4% of our population expected to be over 85) as indicated below:
3.3.3 This means:

- A higher proportion of the G&WCCG population will be in the age group where they are developing chronic diseases including obesity and diabetes, hypertension and cardiovascular disease, and chronic obstructive pulmonary disease (COPD);
- Prevention and mitigation of early disease through behaviour modification (smoking, diet, exercise, and alcohol) should form the foundation of managing the health of these individual;
- This should take place alongside early detection of disease and evidence-based management (e.g. good control of hypertension, cholesterol, blood sugar, and screening for microvascular and macrovascular complications of diabetes);
• Our service planning needs to also provide adequate capacity for dealing with the complications of complex, poorly managed, or late stage disease in secondary care, including consultant and specialist nurse led outpatient clinics, acute care for myocardial infarction and acute coronary syndrome, stroke and transient ischaemic attack (TIA), and rehabilitative services for long term health complications of stroke.

3.3.4 As a result of this ageing profile, an increasing proportion of the population will be suffering from conditions requiring additional care, including:

• Dementia and depression;
• Visual and hearing impairment;
• Long term health conditions as a result of stroke;
• Frailty and being prone to falls and consequent fractures (particularly hip fractures);
• Inability to manage domestic tasks, self care, or mobility on their own.

3.3.5 Additionally, this patient group is more likely to have multiple chronic diseases requiring polypharmacy, and to be in the later stages of the disease when complications have manifested.

3.3.6 Accordingly, we intend to work together with social care services and community health providers to ensure that this population has the support they need to live an independent life in their homes, and to prevent avoidable hospital admissions through the use of appropriate housing, carers, GP home visits, health visitors, pharmacy support, patient education and telehealth/telecare where appropriate.

3.3.7 G&WCCG has a large White/British and Christian population, but significant numbers of minority ethnic and religious groups. This means that particular attention should be paid to:

• The higher risk of disease in particular ethnic groups, and different attitudes to disease and health seeking behaviour;
• The important differences in beginning and end of life care in different ethnic and religious groups.

3.3.8 Whilst overall the area covered by G&WCCG is one of the least deprived in the country, there are pockets of deprivation in Stoke, Westborough and Godalming Central and Ockford. This means:

• Particular attention needs to be paid to addressing the needs of local areas where deprivation is high, and ensuring that those residents are aware of and able to access healthcare.

3.3.9 The headline conclusion of the data on risk factors and specific conditions is that we must have regard to improving morbidity, mortality, and unplanned admissions through:
• Early identification and management of risk factors such as smoking, alcohol, diet, obesity, and exercise.
• Prompt diagnosis and effective management of long-term conditions.
• Improving the quality of care received by people whether at home or in residential care.

3.3.10 Further detailed information regarding the characteristics of our population can be found in the ‘Improving Health’ and ‘Reducing Health Inequalities’ sections below and at www.surreyi.gov.uk. Our strategic and operational plans and interventions are designed to deliver improvements in the care and support for all sections of our population. This Operational Plan for 2015/16 details the targets we have set ourselves and the way in which these will be met.

3.4 Commissioning Intentions 2015/16

3.4.1 Reflecting the needs of our population and as part of our transformational change programme, the following commissioning intentions have been developed. The list is not exhaustive but highlights key tasks we expect to deliver during 2015/16:

• Primary Care Commissioning – whilst respecting our Membership’s decision to not progress co-commissioning of primary care, we feel unified commissioning is important to address the needs of our population. We have obtained the agreement of the Membership to instigate a Primary Care Commissioning sub-group which will monitor and inform on the needs and imperatives of this area;
• Implement 7-day community based services;
• Develop an Integrated Care Pathway;
• Establish clear pathways for ambulatory care sensitive conditions;
• We will work with local specialist, our medicine advisors, and the Surrey Priorities Committee to seek the most cost-effective pathway for the treatment of wet macular degeneration, as allowed by the National legal framework;
• Review all AQP contracts in preparation for reaccreditation in 2016/17
• Implement Cardiology triage, assessment and treatment pathway;
• Develop relationships with the community and voluntary sector, to improve individuals’ and the community capacity to self-care;
• Work with the providers of Mental Health and Learning Disability services to co-design and establish clear pathways covering referral criteria, treatment options and discharge protocols;
• As host commissioner for Child and Adolescent Mental Health Services (CAMHS) we will lead the re-commissioning and procurement of services to meet the emotional well-being and mental health needs of children and adolescents across Surrey;
• Jointly commission children’s Speech and Language Therapy, Occupational Therapy and Physiotherapy;
• Develop an integrated model for End of Life care and treatment;
• Redefine quality standards within our contracted health services, including nursing homes to ensure delivery of high quality care for all
working to ensure that patients are able to access personal health budgets;
- Develop the provider market to enhance access to services locally.
Figure 1: Plan on a page

Operational Plan - Plan on a page 2015/16

Our mission is to ensure that integrated, quality-driven and cost-effective health and social care is in place. By working in partnership we will deliver services locally which reflect patient need and improve the health and well-being of people in Guildford & Waverley.

Outcomes framework
- Improvement in the years of life lost to conditions amenable to healthcare
- Improving the health-related quality of life for people with long term conditions
- Building confidence and satisfaction in care outside of hospital, in general practice and the community
- Reducing avoidable emergency admissions by 5%
- Enabling patients to be discharged in a more timely manner following acute care
- Reducing the proportion of people reporting a poor experience of patient care
- Working with providers to minimise the rates of hospital-acquired infections
- Narrowing the gap in life expectancy for vulnerable and deprived groups

Our Values & Principles
- We strive to improve health, well-being and people’s experiences of the NHS by securing safe, high quality services
- We will seek to ensure value for money and the fair and effective use of resources to secure this improvement

Equality & Diversity - reducing inequalities between the most and least disadvantaged

Communications and Engagement Strategy - ensuring that patients and the public are at the heart of our decisions

Carers Achieving national requirements with respect to NHS commitment to carers

Quality Strategy - Implement the Francis and Hard Truths Report recommendations ensuring a duty of candour

Prevention strategy - behaviour modification (smoking, diet, exercise, and alcohol)

We will improve the health of our local population

We will be a learning, listening organisation

We will manage the health economy within our available budget

We will involve people, respecting and valuing patient & carer experience

Overseen through our governance framework
- Assurance processes, built into our committee structures, will continue to build on our sound governance foundations
- Named commissioning managers and clinicians lead on specific programmes
- Our Governance Framework is structured to ensure the design and delivery of our Transformational Programmes is supported and monitored

Medicine Management Programme supports cost-effective prescribing in primary care

Integrated "wrap around" care in local communities

HR and OD Strategy - Valuing and developing our staff

We will improve the quality and safety of patient services

Urgent Care Programme
- educating patients to access the care first time and ensuring that their needs are met in the right place

Better Care Fund
- Utilising our relationships with key partners and the Better Care Fund to provide integrated health and social care services

Integrated Care Partnership Programme
- Integration of hospital, community, primary care and voluntary services wrapping care around the older frail vulnerable population in five localities
4.0 OUTCOMES

4.1 Delivery across the 5 domains and 7 outcome measures

4.1.1 Overall, G&WCCG has demonstrated excellent achievement against all 5 of the NHS Outcomes Framework core metrics to date. Against the 5 domains, 26 performance framework metrics were published in February 2015, two are rated as red and need improvement (‘patient experience of GP out of hours’ and ‘recording the stage of cancer at diagnosis’) and work has already been invested since this was measured to improve the situation.

4.1.2 The CCG performs exceptionally well for domains one, two and five with some of the highest performances nationally in a number of different key performance indicators, including mortality of under 75s from coronary heart disease, health related quality of life for patients with long term conditions and MRSA and C. Difficile related infections. In the majority of cases, the CCG not only performs above the national median, but also above the cluster median too (clusters defined by NHS England as related groups of similar CCGs). There are a small handful of metrics which are amber rated which the CCG is working to improve, including one year survival from cancers and patient experience within acute providers.

4.1.3 The CCG has robust escalation processes for dealing with performance issues and works jointly with its local providers to ensure that risks and breaches have been mitigated. In addition, each month, the CCG hosts a Systems Resilience Group (SRG), which amongst other things, presents performance data for all providers serving the G&WCCG patch. Issues are identified and partnership solutions are discussed and agreed. Individuals representing each stakeholder are held to account for the actions they agree. In the past, when significant variances in performance or activity have occurred, the CCG have undertaken thorough reviews of provider data and/or root cause analyses to identify the underlying issues. Through the SRG meetings and Clinical Quality review meetings, we will work proactively with providers to seek assurance on how issues have been mitigated and what new processes have been put in place to prevent recurrence. The CCG will continue to work closely with all of its providers to ensure that realistic demand/capacity plans are developed.

4.1.4 The CCG recognises the importance of providers using the NHS Number as the patient unique identifier, to ensure that robust data reports such as SUS for Acute and Mental Health activity are available. The NHS standard contract requires all providers to use the NHS Number and this will be performance managed through the monthly Contract Quality Review Meetings.

4.1.5 It is essential that providers share information with primary care relating to their patients’ episode of care, detailing the assessment, diagnosis and treatment formulation that the patient has been discharged on. We will continue to work with the RSCH to ensure that this % increases whilst retaining quality of information. This performance metric will be managed through the Data Quality Improvement Plan within the RSCH NHS standard contract.
<table>
<thead>
<tr>
<th>Data Source</th>
<th>Metric</th>
<th>Value</th>
<th>Cluster</th>
<th>England</th>
<th>Comparison to England</th>
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<tr>
<td>NHS Outcomes Framework</td>
<td>Domain 1</td>
<td>Potential Years of Life Lose amenable to healthcare - female</td>
<td>1770</td>
<td>1646</td>
<td>1845</td>
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<tr>
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<td>Domain 1</td>
<td>Potential Years of Life Lose amenable to healthcare - male</td>
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<td>Domain 1</td>
<td>Under 75 Mortality from CVD</td>
<td>41.7</td>
<td>54.3</td>
<td>64.9</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 1</td>
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<td>1.68</td>
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<td>Domain 1</td>
<td>Emergency admissions for alcohol release liver disease</td>
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<td>15.96</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 1</td>
<td>One Year survival from all cancers combined</td>
<td>68.9</td>
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<td>41.4</td>
<td>51.3</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 2</td>
<td>Health related quality of life for people with long term conditions</td>
<td>0.8</td>
<td>0.77</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 2</td>
<td>% of patients with long term conditions who feel supported to manage their condition</td>
<td>68.9</td>
<td>64.3</td>
<td>65.1</td>
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<td>Domain 2</td>
<td>Unplanned admission chronic ACS conditions</td>
<td>509</td>
<td>597</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 2</td>
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<td>230.3</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 3</td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>870</td>
<td>959</td>
<td>1164</td>
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<td>Domain 3</td>
<td>Emergency readmissions within 30 days of discharge from hospital</td>
<td>10.24</td>
<td>11.41</td>
<td>11.75</td>
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<td>Domain 3</td>
<td>Hip replacement casemix adjusted health gain</td>
<td>0.46</td>
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<td>Domain 3</td>
<td>Knee replacement casemix adjusted health gain</td>
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<td>Domain 3</td>
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<td>Domain 3</td>
<td>Emergency admission for children with lower respiratory tract infections</td>
<td>341.2</td>
<td>330.6</td>
<td>367.7</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 4</td>
<td>Patient experience of GP out-of-hours services</td>
<td>55.3</td>
<td>63.8</td>
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<td>Domain 4</td>
<td>Patient experience of hospital care</td>
<td>78.2</td>
<td>75.9</td>
<td>76.5</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 4</td>
<td>Responsiveness to Inpatients’ personal needs</td>
<td>69.2</td>
<td>67.4</td>
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<td>Domain 5</td>
<td>Incidence of healthcare-associated infection - MRSA</td>
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<td>NHS Outcomes Framework</td>
<td>Domain 5</td>
<td>Incidence of healthcare-associated infection - C Difficile</td>
<td>13.32</td>
<td>20.23</td>
<td>24.01</td>
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4.1.6 Detailed more fully below are specific outcome targets which have been set for 2015/16, together with the plans we have developed to enable us to achieve those targets.

Table 2: Outcome targets 2015/16

<table>
<thead>
<tr>
<th>Outcome</th>
<th>What is the improvement target</th>
<th>Which of our plans delivers the change?</th>
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<tbody>
<tr>
<td>Reducing Clostridium difficile</td>
<td>Reduce to 20 cases per year</td>
<td>RSCH Infection Control plan</td>
</tr>
<tr>
<td>Improving dementia diagnosis</td>
<td>Improve diagnosis to 67% by 2016</td>
<td>Primary Care Development</td>
</tr>
<tr>
<td>Increasing the number of people treated with psychological therapies</td>
<td>Increase to 15% of the population with a common mental health problem from April 2015</td>
<td>Improving Access to Psychological Therapies Programme</td>
</tr>
<tr>
<td>Improve the seven ambition measures</td>
<td>See Below</td>
<td>See Below</td>
</tr>
<tr>
<td>Deliver the Local Quality Premium</td>
<td>To increase the number of anticipatory care plans in place for people being cared for at home or within care homes by 221</td>
<td>Integrated Care Partnership Programme</td>
</tr>
</tbody>
</table>

Table 3: Outcomes ambitions 2015/16

<table>
<thead>
<tr>
<th>Outcome Ambition</th>
<th>Measure to be used</th>
<th>Ambition</th>
<th>Which of our plans delivers the change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Securing additional years of life</td>
<td>Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area</td>
<td>E.A.1 PYLL (Rate per 100,000 population)</td>
<td>Health and Well Being Strategy Public Health Prevention plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>1429.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>1377.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016/17</td>
<td>1370.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2017/18</td>
<td>1363.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2018/19</td>
<td>1356.6</td>
</tr>
<tr>
<td>2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.</td>
<td>Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).</td>
<td>E.A.2 Average EQ-5D score for people reporting having one or more long-term condition</td>
<td>Planned and Unplanned Care Programme Improving Access to Psychological Therapies Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>78.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>78.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016/17</td>
<td>78.80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2017/18</td>
<td>79.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2018/19</td>
<td>79.20</td>
</tr>
<tr>
<td>Outcome Ambition</td>
<td>Measure to be used</td>
<td>Ambition</td>
<td>Which of our plans delivers the change?</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>----------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| 3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. | - A rate comprised of: unplanned hospitalisation for chronic ambulatory care sensitive conditions.  
- Unplanned hospitalisation for asthma, diabetes, lower tract respiratory infections and epilepsy in under 19s.  
- Emergency admissions for acute conditions that should not usually require hospital admission | | Planned Care Programme |
| 4. Increasing the proportion of older people living independently at home following discharge from hospital. | Currently no indicator | To develop performance metrics that will provide evidence of increasing the number of frail older people returning to their normal place of residence. | Integrated Care Programme |
| 5. Increasing the number of people having a positive experience of hospital care. | Patient experience of inpatient care. | | 'Sign up to Safety' campaign initiated through NHS England |
| 6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community. | Composite indicator comprised of (i) GP services, (ii) GP Out of Hours. | | Urgent Care Strategy |
| 7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. | Currently no indicator | | Integrated Care Programme  
End of Life Strategy 2015/16 |
4.2 Improving Health

4.2.1 Prevention

4.2.1.1 The G&WCCG Prevention Plan sets out the priorities for action by the CCG, either alone or in partnership, to prevent or reduce the levels of ill-health in the local population. The Prevention Plan focuses on five key areas and sets out headline actions that will be taken to ensure better health outcomes for local people that in turn contribute to savings across the health and social care system and wider economy.

This Prevention Plan focuses largely on health behaviours because these have been found to contribute to 30% of the burden of ill-health. We have analysed key health problems and identified the priority areas to address for prevention, given the evidence about what impacts health and the health needs of the local population, as early diagnosis, detection and control of long term conditions, alcohol, physical inactivity, smoking and mental health, including social isolation.

4.2.1.2 We are working with our partners through the Health and Well Being Board across Surrey and with both the local boroughs, Guildford and Waverley, to prioritise and set common goals. The focus in the two boroughs differs so we are working to identify joint priorities. We are also working in partnership with Surrey County Council Public Health and Adult Social Care, in delivering the Prevention Plan and participating in the Better Care Fund Implementation Board.

4.2.1.3 All the initiatives we have identified have been shown to impact on health behaviours. Not only are we addressing primary prevention of ill-health, but also early detection and control of long term conditions that most affect health and health service usage. We have identified organisations responsible for key actions, and reallocation of resources has started by targeting smoking cessation services to operate in the areas of highest prevalence, as identified in the Prevention Plan.

4.2.1.4 We are working with Public Health to identify suitable metrics to measure our progress through the coming year.

4.2.2 Early diagnosis/detection and control

4.2.2.1 Late presentation, under diagnosis and suboptimal management of long term conditions contributes to potentially avoidable ill-health and premature death. Earlier diagnosis of long term conditions enables medical care to be offered at an earlier stage of disease, which may slow progression, prevent further complications and in many instances, be more cost effective. It also allows more time for individuals to be supported to adopt healthier behaviours to help prevent their condition from worsening.
4.2.2.2 Early diagnosis is also important for cancers as there is a direct link between stage of disease at diagnosis and survival. Addressing this issue will form part of the action plan to reduce potential years of life lost (PYLL) amenable to healthcare, a key performance indicator for the CCG, as well as support the Integrated Care Partnership work to maintain active and independent older adults.

4.2.2.3 To prevent further ill-health by improving the detection and management of long term conditions, the CCG will work with G&WCCG local practices and other partners on the following areas.

Table 4: Early diagnosis and detection 2015/16

<table>
<thead>
<tr>
<th>What is our focus for improvement?</th>
<th>Who will be involved in this work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of NHS Health Checks offered and delivered by Practices, particularly in areas of greatest expected health inequality.</td>
<td>Surrey Public Health GP Practices</td>
</tr>
<tr>
<td>Identify the prevalence gap for individual practices across common long term conditions and work with practices to (i) reduce those gaps and (ii) improve the early diagnosis of cancer</td>
<td>Surrey Public Health G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Using available data, identify where management of long-term conditions appears to be suboptimal and work with practices to improve management.</td>
<td>G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Support campaigns that promote the early awareness and detection of long term conditions including Cancers, Hypertension and Diabetes, such as the national Be Clear on Cancer campaigns.</td>
<td>Surrey Public Health G&amp;WCCG GP Practices</td>
</tr>
</tbody>
</table>
What is our focus for improvement? | Who will be involved in this work?
---|---
Active promotion of public health messages to support lifestyle change to prevent onset and reduce progression of disease. | Surrey Public Health G&WCCG GP Practices Guildford and Waverley Boroughs

### 4.2.3 Alcohol

#### 4.2.3.1 Frequent and excessive alcohol consumption has been estimated to contribute to 10% of all deaths in women and 25% in men relating to high blood pressure and conditions such as heart disease and strokes. Alcohol is also the main contributor to the development of liver disease and over a quarter of lip, throat and mouth cancers in women and half in men can be attributed to alcohol.

#### 4.2.3.2 G&WCCG has similar rates of increasing risk drinking to those seen nationally. Although the rate of increase in alcohol-related admissions to hospital has started to slow, Guildford has experienced a 17% and Waverley a 27% increase in alcohol-related admissions to local hospitals compared to 23% nationally between 2008/09 and 2012/13.

#### 4.2.3.3 To reduce the impact of alcohol consumption on ill-health, G&WCCG will actively participate in the delivery of the Surrey Alcohol Strategy and in particular prioritise action and commissioning in the following areas.

#### Table 5: Alcohol 2015/16

<table>
<thead>
<tr>
<th>What is our focus for improvement?</th>
<th>Who will be involved in this work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop an integrated care pathway for people (including children and young people) who need support in tackling alcohol problems so that patients experience seamless care and healthcare professionals know where to refer patients depending on their need.</td>
<td>G&amp;WCCG Surrey PH</td>
</tr>
<tr>
<td>Ensure early identification of alcohol misuse through programmes including NHS Health Checks and the use of the AUDIT-C screening tool.</td>
<td>GP Practices Surrey Public Health</td>
</tr>
<tr>
<td>Commission the use of brief intervention and extended brief intervention in primary care to reduce alcohol consumption among increasing risk drinkers.</td>
<td>Surrey Public Health G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Improve signposting to alcohol services for dependent drinkers in line with <em>Making every contact count</em> and through the Family Support Programme</td>
<td>Surrey Public Health G&amp;WCCG, Local Borough Councils GP Practices</td>
</tr>
<tr>
<td>Reduce acute hospital-related activity through tackling alcohol-related admissions to the Royal Surrey County Hospital, building on existing work to develop the role of the alcohol liaison service and report of A&amp;E attendances for assault.</td>
<td>G&amp;WCCG Surrey Public Health</td>
</tr>
</tbody>
</table>
What is our focus for improvement?

Promotion of prevention messages including alcohol harm reduction to the wider population and targeted messages to women in pregnancy, groups more at risk of increasing/higher risk drinking and those with a mental health problem.

Who will be involved in this work?

Surrey Public Health
Local Borough Councils
G&WCCG
GP Practices

4.2.4 Smoking

4.2.4.1 Smoking remains the major preventable cause of early death and reducing tobacco use is the single most effective means of improving health. More than a quarter of all cancer deaths are attributable to smoking. Eighty per cent of deaths from respiratory illnesses including lung cancer, bronchitis and emphysema and 17% of deaths from heart disease are related to smoking.

4.2.4.2 To help reduce the impact of smoking on ill-health, G&WCCG will particularly focus attention on those areas or groups where smoking prevalence is particularly high, as well as ensure greater use of the Surrey Stop Smoking service with its high success rate.

Table 6: Smoking 2015/16

<table>
<thead>
<tr>
<th>What is our focus for improvement?</th>
<th>Who will be involved in this work?</th>
</tr>
</thead>
</table>
| Maximise referrals to the Stop Smoking Service, using a variety of opportunities to raise the issue including reviews, NHS Health Checks, 6 week post natal check and identifying those currently prescribed stop smoking pharmacotherapy. | G&WCCG
GP Practices                                      |
| Encourage practices in the target areas sign up to Public Health agreements to deliver smoking cessation services. | Surrey Public Health
G&WCCG
GP Practices                                      |
| Work with local partners to identify barriers and opportunities for the delivery of stop smoking support to those in the target areas. | Surrey Public Health
GP Practices
Local Borough Councils                           |
| Ensure patients on registers for COPD and Asthma have their smoking status recorded and are referred to Stop Smoking Services. | G&WCCG
GP Practices                                      |
| Work with the RSCH and community providers to embed the delivery of brief intervention for smoking and referral to Stop Smoking Services into appropriate clinical pathways. | G&WCCG
Surrey Public Health                               |
What is our focus for improvement?

Ensure relevant community contracts, including those for looked after children and community adolescent mental health services, support key messages of the Surrey Tobacco Control Alliance. Including reducing exposure to second smoke and encouraging smokers to quit.

Ensure all relevant frontline staff are trained in level 1 and level 2 smoking cessation training and local health care providers support awareness raising campaigns such as Stoptober.

Work towards the Workplace Wellbeing Charter which encourages smoking cessation as part of a healthier workplace.

Who will be involved in this work?

G&WCCG
Local Borough Councils

GP Practices
Local Borough Councils

G&WCCG
GP Practices
Local Borough Councils

4.2.5 Physical activity

4.2.5.1 Maintaining an active lifestyle has been estimated to bring about a 20-35% risk reduction in mortality and can reduce the onset of type 2 diabetes by up to 40%, depression by 30%, high blood pressure by 33% and heart disease by 35%. It is also a core component of maintaining a healthy weight in adults and children and can improve cognitive function and academic achievement. Equally important is the role physical activity has in enabling people to remain independent and able to carry out everyday tasks as they age, reducing the need for additional assistance or adaptations to everyday life.

Table 7 Exercise, and obesity rates in Guildford and Waverley Boroughs compared with England

4.2.5.2 While local residents are more active than the national average, nearly 40% of local adult residents do not take sufficient physical activity to benefit their health. Whilst levels of overweight and obesity in Guildford and Waverley’s
children are lower than that seen nationally, 1 in 4 (272) local Year 6 children are overweight or obese. To help local people be more active G&WCCG will work with partners and support the following actions:

Table 8: Physical Activity 2015/16

<table>
<thead>
<tr>
<th>What is our focus for improvement?</th>
<th>Who will be involved in this work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider the commissioning of a physical activity care pathway or supporting the establishment of Green Prescription programme with links to pathways for mental health, cardiovascular disease, cancers and weight management.</td>
<td>Surrey Public Health G&amp;WCCG Local Borough Councils</td>
</tr>
<tr>
<td>Maximise appropriate referral and promotion of local physical activity and weight management programmes for children, such as HENRY and any future child weight management services.</td>
<td>Surrey Public Health GP Practices</td>
</tr>
<tr>
<td>Identify adults who are inactive using the GPAQ (early identification tool) and through initiatives such as NHS Health Checks.</td>
<td>GP Practices Surrey Public Health</td>
</tr>
<tr>
<td>Work with local practices to deliver brief advice for physical activity and encourage sign posting to local exercise referral programmes and wider physical activity opportunities particularly for older adults.</td>
<td>Local borough Councils GP Practices</td>
</tr>
<tr>
<td>Ensure that that appropriate patients are referred to rehabilitation and prevention programmes including cardiac rehabilitation and falls prevention.</td>
<td>GP Practices G&amp;WCCG</td>
</tr>
<tr>
<td>Support Waverley and Guildford Borough Councils in the promotion and organisation of local physical activity opportunities, including walking, cycling, use of green space and play and recreational facilities and national campaigns such as Change for Life. With a particular focus on older people.</td>
<td>Local Borough Councils G&amp;WCCG GP Practices Surrey Public Health Active Surrey</td>
</tr>
<tr>
<td>Work towards the Workplace Wellbeing Charter which encourages physical activity as part of a healthier workplace.</td>
<td>G&amp;WCCG GP Practices Local Borough Councils</td>
</tr>
</tbody>
</table>

4.2.6 Mental Health and Wellbeing

4.2.6.1 The Five Year Forward View establishes the importance of reducing the inequalities that are experienced by people with mental health illness. We will ensure that people with physical health problems, especially those with chronic diseases, and who are at increased risk of poor mental health, particularly depression and anxiety will have their needs met. It is estimated that depression almost doubles the risk of developing coronary heart disease in later life and people with mental health problems also have a higher prevalence of diabetes. People with a mental illness also have a 10 year lower life expectancy than those without such an illness.
4.2.6.2 Over 5% of the Guildford and Waverley population have been diagnosed with depression which is the highest of all Surrey CCGs. Approximately 0.7% of the Guildford and Waverley population are registered with a diagnosis of severe or enduring mental health problems. It is estimated that 7.2% of 5-15 year olds in Guildford and 6.7% in Waverley have a mental health disorder, a similar proportion to that seen across Surrey. Social isolation can contribute to poor mental health, particularly in the elderly. 27% of households in the G&WCCG area are one-person households of which 22% are aged over 65.

4.2.6.3 To help improve people’s mental health and wellbeing and prevent social isolation G&WCCG will work with partners and support the following actions.

Table 9: Mental Health 2015/16

<table>
<thead>
<tr>
<th>What is our focus for improvement?</th>
<th>Who will be involved in this work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve detection of common mental disorders and access to appropriate services and continue to refer to and support delivery of the Mental Health Promotion Service: First Steps, Community Connections services and IAPT, particularly in those wards with the highest incidence.</td>
<td>G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>We will support people to manage their own mental health – Staying emotionally healthy, making informed choices of treatment, managing conditions and avoiding complications.</td>
<td>G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Work with local borough colleagues and voluntary and community agencies to establish and promote befriending, volunteering and social prescribing services to reduce social isolation and improve mental health.</td>
<td>Surrey Public Health G&amp;WCCG Local Borough Councils</td>
</tr>
<tr>
<td>Ensure screening of patients with long term conditions for depression to enable referral to support services, including, First Steps, pain management and patient self-management courses for long term conditions.</td>
<td>G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Encourage front line staff to attend Domestic Abuse training and increase referrals to domestic abuse services and Practices to sign up to multi-agency data sharing protocol.</td>
<td>Local Borough Councils GW GGC GP Practices</td>
</tr>
<tr>
<td>Ensure early identification of alcohol misuse, smoking and physical inactivity amongst people with mental ill health and depression, through initiatives including NHS Health Checks.</td>
<td>Surrey Public Health G&amp;WCCG GP Practices</td>
</tr>
<tr>
<td>Ensure the development of a physical activity care pathway promotes opportunities for people with mild to moderate depression, including local walking and physical activity opportunities to help reduce social isolation.</td>
<td>Surrey Public Health G&amp;WCCG Local Borough Councils</td>
</tr>
</tbody>
</table>
**What is our focus for improvement?**

Promote mental health campaigns, including: Time to Change-Surrey and 5 Ways to Wellbeing and ensure staff receive Mental Health Awareness and suicide prevention training.

**Who will be involved in this work?**

G&WCCG
GP Practices
Local Borough Councils

### 4.3 Reducing Health Inequalities

For a CCG to reduce health inequalities it needs to understand the composition of its population. There follows an extract from the Annual Equality Report 2014/15, which describes the groups of people in our area that have worse outcomes and experience of care. The CCG has built its commissioning intentions for 2015/16 on our demographic information to ensure the services it commissions reduce health inequalities.

#### 4.3.1.1 Age

Relative to England, G&WCCG has:

- A smaller proportion of children aged 0-4
- A larger proportion of young people aged 10-19
- A smaller proportion of young adults aged 25-34
- A slightly greater proportion of older adults aged 45-64
- A larger proportion of adults aged 75+

*Table 10 Population pyramid for Guildford and Waverley CCG
Darker outlines show the profile of the England population.*

As we stated in 3.3.2, the G&WCCG population profile is weighted towards the older adult population when compared nationally.
4.3.1.2 Ethnic Group

- The ethnicity of G&WCCG is 85.7% White British whilst the largest ethnic minority group is Other White at 5.9%.
- The Gypsy, Roma and Traveller communities are a significant minority ethnic group living in the CCG.
- The CCG has engaged proactively with these communities in its commissioning lead role across Surrey for children and maternity.
- It is also recognised by the CCG that a significant number of Nepalese families have settled in South West Surrey. Whilst the majority of these families live near to the military bases in NHS Surrey Heath CCG, it is expected that movement will naturally occur over the years.

4.3.1.3 Religion

- G&WCCG is predominantly Christian, with 62.1% of the population stating it as their religious affiliation in the last Census, with the next largest group having no religion at 26.7%.

4.3.1.4 Deprivation

The deprivation score (Index of Multiple Deprivation 2010) calculated for G&WCCG for 2012 is 7.98 which is in the least deprived tenth of all CCGs in England and is the fourth least deprived out of 211 CCGs. None of the LSOAs in the G&WCCG area are in the most deprived national quintile.

- However, there are local deprivation hotspots (where we expect worse health outcomes), with the most deprived areas being in the wards of:
  - Godalming Central and Ockford
  - Stoke
  - Westborough
- Westborough is one of the Surrey priority places which are areas of increased inequality and deprivation relative to the rest of Surrey.
- Life expectancy is lowest in Haslemere Critchmere and Shottermill at 79.9 years, 8 years shorter than Burpham and Blackheath and Wonersh at 87.9 years, indicating significant health inequalities across the area.
- Worryingly, life expectancy in Alfold, Cranleigh Rural and Ellens Green has fallen by 4.5 years from 1999-2003 to 2007-2011 indicating that more work needs to be done in this area to address health needs.
  - A number of wards have a life expectancy which is statistically significantly lower than Surrey and which might warrant attention.
- PHE report male life expectancy at 81.7 years and 84.9 for females in G&WCCG compared with 78.9 and 82.8 for England respectively for the period 2008-2012.

4.3.1.5 Specific Groups

The specific groups requiring a targeted approach in G&WCCG include: older people, carers, the Gypsy, Roma, and Traveller (GRT) population, the armed forces community (serving members, reservists, veterans, and families) and
offenders serving community sentences, those on probation and ex-offenders. These are the specific groups that the CCG is aiming to reach with its work:

- Carers: more than 18,300 people of all ages provide unpaid care; 2,200 are over 65 providing >20 hours a week
- Older people: particularly with the high rate of falls, hip fractures, and increasing impact of excess winter deaths on local populations
- Gypsy, Roma and Traveller community: Surrey has the 4th largest GRT community in the country. G&WCCG has 14 authorised GRT sites
- Armed service personnel and veterans: large number of army personnel and family at Pirbright, Deepcut and Keogh barracks and veterans and reservists in the local area, with particular health needs.

The CCG acknowledges the important role of carers within the community and views carers as equal partners in the provision of health care. The CCG has highly developed and evolved plans in place for joint working with the local authority. These are largely discharged through the function of the multiagency Surrey Carers’ Commissioning groups. Surrey has a detailed adult carers and young carers JSNA, a Surrey Adult Carers Strategy and a Surrey Young Carers Strategy. We also have a Carers and NHS providers’ network.

Our commissioning arrangements cite the Surrey Carers Pathway as being pivotal to our providers identifying, recognising and supporting carers (young and old).

In April 2014 we launched our NHS Carer’s Prescription, a mechanism that allows NHS healthcare staff to refer identified carers to multiple carers’ services including carers’ assessments. Overall health referral rates to carers’ services have seen an increase of 55% on average on the same period as last year which evidences the increased awareness by health professionals.

We anticipate that this will continue to rise during 2015/16 with the roll out of the Carer’s Prescription. Our Surrey Carers Dashboard evidences that we have supported 20,610 carers in 2014/15. This reflects year on year growth of 18,000 in 2013/14 and 13,000 in 2012/13.

We are working with all providers towards a whole systems approach to ensure carers receive the right care at the right time in the right place. We recognise that the top priority for carers is achieving a break outside of caring and our nationally recognised GP Carers Breaks service and home based care flexible breaks service will continue to be made available in 2015/16.

We are implementing the School Nurse Young Carers Pathway and promote whole family assessments and we continue to work with pharmacy to raise awareness of carers and promote Carers Friendly Pharmacy services.

We will review our Flexible Working policy to ensure that CCG employees who are carers are fully supported to work flexibly to allow them to meet their carer responsibilities.
4.3.1.6 Equality Delivery System

The Equality Delivery System programme will run over 9 months from April to December 2015 through scheduled meetings with providers followed by focused Listening Events with patients and the public from a range of communities that have experienced the services. The aim will be to thoroughly review two services from the point of view of vulnerable groups of patients.

In 2014/15 we reviewed end of life care services; the new musculoskeletal care pathway and psychological therapies in primary care. Recommendations from this EDS review will be shared with the providers and, where relevant, the host commissioner (mental health care) will feed into action plans for 2015/16.

4.3.1.7 Cost-effective interventions

The National Audit Office identified three key, cost-effective interventions to reduce the gap in life expectancy in 2007 following the Marmot Report earlier that decade:

- Increase the prescribing of drugs to control blood pressure by 40%;
- Increase the prescribing of drugs to reduce cholesterol by 40%;
- Double the capacity of smoking cessation services and target such improvements in areas of greatest need i.e. where the rates of co-morbidities are highest.

4.3.1.8 Making the best use of Medicine

The CCG has a dedicated medicines management team consisting of pharmacists, a dietician and a respiratory nurse specialist.

Medicines optimisation supports cost-effective prescribing in primary care, as well as helping patients to manage their medications better. Good medicines optimisation can help reduce the likelihood of medication errors and patient harm. Adverse drug reactions can lead to hospital admissions, particularly among vulnerable groups such as frail and older persons. In addition, poor compliance with medicines prescribed for long term conditions can lead to poor health outcomes and significant waste.

Examples of medicines optimisation initiatives that are being undertaken or in the process of implementation include:

- Medicines Optimisation Services to Support Patients in Care Homes

G&WCCG has in excess of 2000 patients in 73 care homes, many with a high level of pharmaceutical needs. Previously the Medicines Management team has been involved in a number of successful care home projects which have evaluated the benefits of Medication Review and Medicines Ordering Processes in a number of care homes. The CCG have invested in 1.6WTE dedicated Medication Review Pharmacists to undertake a medication review for every patient in a care home setting.
• Polypharmacy medication reviews for patients not residing in a care home

There is limited evidence nationally of studies looking at polypharmacy reviews on high risk patients outside a care home setting. Negative consequences of polypharmacy include adverse drug reactions, drug-drug interactions, medication errors and non-adherence. It is suggested that up to 50% of medicines are not taken as prescribed. Adverse drug reactions to medicines account for 5-17% of all hospital admissions. The CCG have invested in dedicated pharmacist resource to medication reviews for patients taking 10+ medications who do not reside in a care home setting.

• Optimising Oral Nutritional Supplementation (ONS) in Primary Care

A dietician has been appointed as a community nutritional specialist to champion the review of ONS in the CCG. The post holder will be involved in up-skilling local clinicians to undertake appropriate ONS reviews, delivering training on MUST (Malnutrition Universal Screening Tool) screening and provide sustainable good prescribing practice. The post holder will work with the care home pharmacists supporting review of patients on ONS in care homes.

• Optimising respiratory care in patients with asthma

The CCG has seconded a specialist respiratory nurse to champion the up-skilling of local clinicians in reviewing patients aged over 12 years with asthma on high dose inhaled corticosteroids and stepping down their therapy to a safe yet efficacious level as advised by NICE.

4.3.1.9 Local decision making through the Prescribing Clinical Network

Many of the successes over the past 5 years have been achieved through effective clinical engagement and decision making across the wider health economy, with the Prescribing Clinical Network (PCN) being the focal point of these activities.

The work of the PCN can be summarised as follows:

• Horizon Scanning
• Managed entry of new drugs
• Managed exit of drugs following loss of patent exclusivity
• Interpretation and implementation of NICE guidance
• Having a consistent approach to value for money and opportunities for investment and disinvestment
• Ensuring governance systems are in place to facilitate the safe and appropriate prescribing of drugs across the interface whilst taking into consideration the allocation of funding and financial flows
• Promote equity of access to medicines across Surrey by collaborative working across all participating PCN organisations
• Implementation of patient safety alerts and other directives in relation to drug/patients safety issues
4.3.1.10 Other Prevention Initiatives

The CCG has identified optimal anticoagulation for patients with atrial fibrillation at risk of stroke as an important prevention programme that requires review in 2015/16. Currently, all GP practices provide anticoagulation management via a Locally Commissioned Service. The programme includes provision of training for the frontline healthcare professionals delivering the service and improved monitoring of performance.

4.4 Parity of Esteem

We have established a Parity of Esteem Programme in order to focus effort and resources on improving clinical services and health outcomes. The Parity of Esteem programme is currently being developed through discussions with stakeholders but we have identified three areas as initial priorities for urgent focus during 2015/16: These are:

- **Emotional Health and Wellbeing Strategy** - The Surrey & NE Hants ‘Emotional wellbeing and mental health strategy’ Everybody’s Business’ developed in partnership with the CCG’s and Surrey County Council is in place and was driven as one of the clear priorities of the Surrey Health and Wellbeing Board. This strategy identifies a wide range of actions across 5 priorities, deliverable across the wider community to drive parity of esteem for mental health. Within these priorities is a focussed approach for mental health promotion inclusive of wider workforce mental health awareness training to be delivered by public health to a range of agencies including primary care, acute hospitals and ambulance staff.

- **Surrey Crisis Care Concordat** - A local declaration and Action Plan has been signed up to and is being driven by the formation of a strong partnership across Surrey including, CCG’s, Surrey Police, South East Coast Ambulance Service, Surrey County Council, acute hospitals and the voluntary sector. Some of the initial and significant achievements of this action plan, which has parity of esteem as it’s driving message are:
  - Introduction of ambulance response to section 136 within a timely manner to help ensure that people in a mental health crisis are shown the same priority and urgency as those experiencing a physical health crisis.
  - Significant progress and support from Surrey Police to ensure non-criminalisation of people experiencing a mental health crisis that may come into contact with their service - this has in part been evidenced by a significant decrease in the number of individuals inappropriately held in custody as ‘a place of safety’ when under section 136- moving from 12-19% in 13/14 to 5-6% in 14/15.
  - Successful pilot placing SABP staff in Surrey Police call centre has been extended and is showing positive impact on number and appropriateness in use of S136.
  - Local ‘safe haven’ café approaches across Surrey - providing people with an effective, accessible alternative to A&E or
secondary care MH services when they experience, or to prevent, a mental health crisis

- Working closely in partnership with the Acute Hospitals across Surrey to ensure appropriate environments and protocols to support people presenting in a mental health crisis.
- Development of an information spine allowing all agencies to access information to inform and guide the right response for that person.

- **Choice and Access Standards** - We will ensure that the mental health choice will be on relevant providers SDIPs ensuring they fulfil their requirements. We will work with GPs to ensure they know available services under choice and how to assess when choice is or is not clinically appropriate. The CCG has a plan to achieve the dementia and IAPT targets and is putting in place through contracts with providers and SDIPs preparation to achieve the new access standards for EIP that need to be maintained from April 2016. A workshop is planned with the EIP regional lead and Surrey commissioners and providers to support our work and preparedness. Integration with 111 and 24/7 HTT to prevent vulnerable ending up in police cells is being progressed through the Transforming Challenge Award for mental health crisis care concordat work

- **Learning Disabilities** - The numbers of NHS directly funded in-patients at inappropriate and often high cost establishments away from their local communities will be reduced compared to 2013/14. This will be coupled by redesign of LD local inpatient beds to more responsive intensive support response enabling earlier identification of a deterioration in a person’s condition and earlier intervention to reduce the incidence of breakdowns and admissions to assessment and treatment beds. Above all care packages will be designed around individuals to create bespoke personal services that are sustainable and adaptable to changing need. Work will commence to improve transition into adult services maintaining and improving an individual’s wellbeing and abilities. This will involve a changed strategic approach with our lead LA partners creating formal integrated commissioning arrangements able to address the ‘whole system’ and required mutual interaction with housing, social and related services to deliver the Transforming Care Concordant mandate. This partnership also will enable better assistance of families and carers of those receiving NHS services. A common commissioning approach will be taken in partnership with specialist providers such as Surrey & Borders NHS Trust to rework services accordingly with a shift of resources from in-patient to community support services.

- **Expansion of Personal Health Budgets** - A small number of people with a learning disability were offered PHB through CHC. Through 15/16 we will be expanding this and working with the Local Authority to look at the feasibility of initiating joint health and social care budgets.
• **Improving Access to Psychological Therapies (IAPT)** – this is a national programme to roll out access to talking therapies for people suffering from depression and anxiety disorders. Whilst we have made significant progress in this area we also know that there is more to do to provide target access to these invaluable therapies which help patients manage their conditions and improve their quality of life. We aim to improve this within the process of procuring and ensure our providers are delivering IAPT for children. We have an ambition to meet the national target and increase access so that at least 15% of those with anxiety or depression have access to clinically proven talking therapy services, and that those services will achieve 50% recovery rates. G&WCCG has taken a number of steps to achieve the 15% referral rate and the new access targets for 15-16. A major step towards this goal is the opening up of services to self-referral. This approach mirrors the national model of IAPT services and brings with it a number of advantages. Where this model has been adopted locally the benefits that have been seen include; increase in referral rate of 6-7%. Patients who self-refer also have a lower DNA rate. The new self-referral option will be promoted amongst our GPs and the dialogue with our IAPT providers will continue in order to ensure that all capacity is being used efficiently and appropriately.

• **Improving diagnosis and support for people with Dementia** – we are committed to making considerable progress towards diagnosis, treatment and care of people with dementia during 2015. We recognise that the key to this is a diagnosis as this can unlock access to support services. We are aligned with the national ambition for two thirds of people with dementia to have received a formal diagnosis and be accessing care and support. We are also working with local providers to map the support available for people who are newly diagnosed with dementia and their carers.

• **Improving awareness and focus on the duties within the Mental Capacity Act** – We are aware of the duties and expectations in relation to the Mental Capacity Act that spans patient groups such as those with enduring mental illness and people with dementia. The Act is of central importance in ensuring delivery of healthcare to our local population. We are working within the collaborative commissioning arrangements to respect and reconcile patients’ rights to make decisions about their care and treatment with the right to be protected from harm, and requiring others to act in the patient’s ‘best interests’ where they lack capacity for a particular decision.
4.5 Operational Delivery 2015/16

4.5.1 We are committed to achieving the best configuration of primary care, health and social services to meet the population’s needs. This is about people receiving the right care at the right time and by the right person in the right place. Driving integration deeper across all providers and commissioners will dramatically improve the quality of care and services for patients.

4.5.2 In order to transform current provision we will work towards implementing a Multispecialty Community provider model in line with the Five Year Forward View. In order to achieve this we will dissolve traditional provider boundaries that may act as a barrier to access. We will work to ensure that patients with long term conditions needs are met through joined up, connected ‘episodes’ of care.

4.5.3 We will continue to work towards seven day services through working systematically and collectively across whole health and care communities to achieve equality of access. To deliver seven day services that meet patients’ needs, models must include both health and local government services, covering a shared population. Primary care and other non-hospital health settings, secondary care, community health services and social care, housing and the voluntary sector all provide vital inputs into care packages and are brought together within Surrey wide and Local Borough Health and Well Being Partnerships and enabled by the Better Care Fund (BCF). NHS England and the Local Government Association’s aim is for a seamless health and social care economy.

4.5.4 To reduce variations in when and how patients receive care, we will develop a proposal to determine how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities.

4.5.5 Guildford and Waverley Local Health Economy is performing well in meeting the needs of the local population, for example Guildford and Waverley are the 18th lowest CCG in the country for avoidable admissions. This poses a challenging environment in which we need to achieve further and deeper improvements in patient care.

Chart 4: Emergency admissions
4.5.6 Good progress has been made against the plans set out in our 2 year Operating Plan 2014 - 2016 in which we set out to improve services and deliver demonstrable benefits for patients.

4.5.7 We continue to work towards delivering the following outcomes as set out in the 2 year operating plan 2014 - 2016:

- Changing the way that planned care is provided by reducing the need for people to always travel to hospital and making services available closer to home;
- Improve the way that unplanned care is provided by expanding services across seven days a week;
- Increasing access to psychological therapies for people with a common mental health problem;
- Improving access to care for local people with a Learning Disability;
- Better co-ordinating End of Life Care;
- Making the best use of medicines by reducing the amount that is wasted.

4.5.8 The focus of the CCG’s commissioning intentions for 2015/16 will be to work with partners to continue to develop the schemes that are designed to support our financial challenge and the required whole system transformation and integration of services.

4.5.9 These plans aim to achieve the following key outcomes:

- Patient and carer experience improved;
- Older people supported to remain in their normal place of residence;
- Reduce non-elective admissions in to hospital (general & acute);
- Reduce the average time patients stay in hospital;
- Increase the number of patients with long term conditions who are able to self-manage and self-care;
- Optimise new and follow up appointments;
- Enable patients to be cared for and die in a place of their choice;
- Reduce health inequalities and address the needs of protected groups within our communities in terms of equality of access and outcomes.

4.5.10 In 2015/16 the CCG is setting out its expectations with regards to activity provided by the local Acute Hospitals. This will be significantly less than in previous years. In line with our commissioning intentions referred to above and our 5 year Strategic Plan, the CCG is investing more into developing community based solutions that provide care closer to home.

4.5.11 The activity assumptions for Royal Surrey County Hospital have been developed at HRG level and jointly tested and assessed against the operational plans for their validity.
4.5.12 G&WCCG are working in partnership to develop and deliver the following 6 programmes of service transformation during 15/16:

1. Integrated Care
2. Unplanned Care
3. Children and Young Peoples
4. Acute Mental Health
5. Planned Care
6. Medicines Management

1. **Integrated Care Programme**

The aim of this programme is to develop local providers’ integrated health and social care services that wrap around the frail older population of Guildford and Waverley. The provision of proactive care will reduce:

- emergency admission for ambulatory conditions
- ambulance conveyances
- demand on emergency and out of hours services
- demand for social care provision

The Royal Surrey County Hospital has been working with the CCG and other partners during the last year to put in place viable community and primary care service improvements that will allow the planned and safe reduction in the hospital general and acute bed capacity. A detailed plan has been established that is triangulated across the health economy with specific milestone dates for the bed closures. The capacity reduction is possible through the expected improved efficiency in patient management reducing length of stay and also the frailty management by primary and acute medical teams preventing emergency admissions.

The plan sees the bed stock reduce from 287 to 243 during the full year. The delivery of the bed reduction programme is being jointly project managed by the RSCH and the CCG with a weekly delivery group chaired by the Chief Executive of the RSCH and the Chief Officer of the CCG.

Guildford and Waverley partners are collectively committed to achieving the ambition to transform care that meets the needs of the frail older population. The Integrated Care Partnership Programme has been established and is working at pace to support the co-creation of an integrated locality based service model that brings together health, social care and the voluntary and community sector.

In order to achieve these outcomes the Programme is made up of the following schemes.

<table>
<thead>
<tr>
<th>I.</th>
<th>Integrated Care Partnership (ICP)</th>
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<tbody>
<tr>
<td>II.</td>
<td>Frailty initiative</td>
</tr>
<tr>
<td>III.</td>
<td>Age UK Integrated Care Programme</td>
</tr>
<tr>
<td>IV.</td>
<td>Falls pathway</td>
</tr>
</tbody>
</table>
I. Integrated Care Partnership

The new model of care is designed to shift resources from reactive care to proactive care, from hospital based care to community based care, and from treatment to prevention. It is anticipated that the costs of putting in place the new service model will be funded by a reduction in the hospital based expenditure for these patients (for example because fewer hospital beds will be needed). Local partners will focus on delivering four key initiatives to begin to deliver this new model of care and make a step change in the care:

<table>
<thead>
<tr>
<th>1. Staying Healthy Programme</th>
<th>A programme of interventions that support older people to stay well, active and independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Population Risk Stratification</td>
<td>Systematically introducing Risk Stratification of all older people (65+) and identifying those at greater risk.</td>
</tr>
<tr>
<td>3. Primary Care based Multi-Disciplinary Assessment, Care Planning and effective Care Co-ordination</td>
<td>Looking after the needs of those older people identified through the Risk Stratification process as being at risk, through effective Multidisciplinary Teams (MDTs) who assess their needs, and agree Individual Personalised Care Plans with their (and their carers’) full participation. Ensuring that the ongoing care of those at risk is effectively co-ordinated by introducing a cadre of skilled Care Co-ordinators who can offer proactive advice to older people at risk and to their carers.</td>
</tr>
</tbody>
</table>
| 4. Proactive Specialist Care | To develop a coordinated service which proactively supports at risk older people, with the aim of keeping them as healthy and independent as possible. Key elements of the service offering will include:  
  ▪ Outpatient Day Assessment Service providing a variety of ambulatory services for frail elderly people  
  ▪ Provision of expert in-reach support to local nursing homes  
  ▪ Local specialist outreach clinics  
  ▪ Focused support of the Locality Proactive Care Team |

The Better Care Fund (BCF) was announced by the Government in 2013 to ensure a transformation in integrated health and social care. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The fund in Guildford and Waverley is budgeted to be £12.25m of capital and revenue funding in 2015/16.

A Joint Commissioning Group co-chaired by the CCG and Surrey County Council will oversee the BCF.

The Local Joint Commissioning Group will work with partners to ensure that the following conditions for success are in place in Guildford and Waverley:
• Understanding of Need. (through, for example risk stratification which helps us to understand who in the community may require hospital care)

• Shared Delivery – All partners working together to achieve the shared aims. Build improved joint working across health, social care and the voluntary and community sector and with people who use and rely on services.

• Key Support structures and systems
  – Innovative payment systems – making sure that our contracts provide incentives for doing the right thing.
  – Tight governance across commissioners and providers – making sure we get good value for money.
  – Clinical and managerial leadership on the ground – making sure we involve people in developing the plans who understand how things work in service delivery.
  – Information available through interoperable system to provide secure access to partners about patient need, building on our work to share important information that helps people to provide the right support and care.
  – Support for families and patients – involving people who use and rely on services in design and review of services.

The Joint Commissioning Group will ensure that the investment is achieving agreed targets and having a positive impact against the overall aims of the BCF in Surrey:

• Enabling people to stay well:
  – Maximising independence and wellbeing through transformed prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs.

• Enabling people to stay at home:
  – Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care.

• Enabling people to return home sooner from hospital:
  – Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.

G&WCCG has five schemes operating within the context of the BCF:
2. Telecare.
3. Virtual Wards for older people.
5. Virtual Wards for people with Dementia.
There are 25 areas of activity within the five schemes and these are being developed so that a range of health and social care investment is brought together into a coherent whole that delivers better outcomes within the resources available. This will include better alignment with the QIPP targets and ensuring BCF schemes support the Integrated Care Partnership programme.

Through the BCF Local Joint Commissioning arrangement there are opportunities to develop an alliance or lead provider contract models that will ensure that resources available are utilised most effectively to improve outcomes for the local frail older population.

There are a number of integrated commissioning and contracting models, for example: (i) in an alliance contract model, providers would enter into a single arrangement with the commissioners to deliver services; or (ii) a lead provider would receive a capitated budget to meet the needs of a section of the population.

Diagram 1: Alliance Contract Model
Diagram 2: Lead provider Contract Model

We will continue to explore the opportunity to develop an alliance or lead provider contract model, using capitation based models, that in the longer term will ensure that resources available are utilised most effectively to improve outcomes for the local frail older population.

II. Frailty Initiative

The aim of this scheme is to provide additional primary care interventions into medical and nursing care for older patients diagnosed with frailty. The following interventions will focus on improving physical, mental and social functioning to avoid adverse events, injury and ultimately admission to secondary care:

- We will increase the portion of patients commonly addressed using Risk Stratification from 2% to 5% of the over 65 population. This will allow us to target appropriate resources on this group;
- GPs prioritise care of this cohort of patients;
- Improved patients experience;
- Preventable admissions will be avoided;
- The amount of time people spend in their normal place of residence will be increased;
- Health related quality of life of people with one or more long-term conditions, including mental health conditions will be significantly increased;
The proportion of older people living independently at home following discharge from hospital with a package of support will be increased.

Transforming the care provided for vulnerable older people in the community will consist of advanced care planning, involving specialist teams, to provide a holistic person centred service in the community which will reduce admissions, facilitate discharge with a package of supported care, and increase patient experience and health outcomes.

Chart 5: Specialty Geriatric Emergency admissions M10 2014/15

This model of care meets the holistic needs of individuals in their community aiming to maintain their normal place of residence. The Frailty Service in 14/15 has evidenced that being responsive to peoples’ needs reduces ambulance conveyances and emergency admissions as well as length of acute and community hospital stay.

III. Age UK Integrated Care Programme

Guildford and Waverley has been successful in being awarded Age UK Integrated Care Programme 15/16 status, which brings together voluntary, health and care organisations in the local area to help older people who are living with long-term conditions and are at risk of recurring hospital admissions.

Working with the organisations to co-design and co-produce an innovative combination of medical and non-medical support that draws out the goals the older person identifies as most important to them. Through the programme, Age UK staff and volunteers will become members of the locality primary care led multi-disciplinary teams, providing care and support in and through the local community.

IV. Falls Pathway

Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of falling and the severity of the consequences are associated with growing older and the rising rate of falls is expected to continue as the population ages.

Currently there is no collaborative falls pathway within G&WCCG. We will develop a Falls Pathway in conjunction with RSCH, Virgin Care Ltd and other local providers to:
• Reduce the number of acute admissions related to falls;
• Improve outcomes and improve efficiency of care after a fall;
• Early intervention – linking acute and community care services;
• Prevent frailty, preserve bone health, reduce accidents;
• Robust pathway to be part of Integrated Care Partnership Programme.

Workforce Planning for Integration

The workforce implications of implementing the Integrated Care Programme will be the need to increase community health services staff. This will be achieved predominantly through changing working arrangements for hospital staff to working in the integrated proactive care team in each locality. For example, interface geriatricians will work in community settings improving the access for the frail older population to specialist care without having to go to the hospital. This will generate a reduction in the amount of time people spend in hospital and reduce excess bed days. The healthcare and social care providers are committed to planning and commissioning education and training in partnership with Local Education and Training boards.

We are working closely with the Royal Surrey County Hospital as well as other key stakeholders, including patients and their carers to ensure the transformation of services is owned by all and outcomes are agreed in partnership.

This approach will ensure that the resulting impact and implications on the provision of hospital care will be supported as a whole system change and the right care is delivered by the professionals with the right skills in a timely manner. Proposed and planned changes are well understood between the organisations and we are working together to manage the implications and in particular the workforce implications.

2. Unplanned Care Programme

The whole system transformation of urgent and emergency care services in Guildford and Waverley is a major undertaking and there will be many challenges and opportunities along the way. We know that many parts of the system are already coping with sustained pressure and multiple demands, particularly GP practices which have themselves experienced significant increases in patient consultations in recent years.

The right conditions and environment will allow new services to be developed, safely changing the whole urgent and emergency care pathway, from start to finish. A significant component of the operational delivery focuses on providing high quality care in the most appropriate setting.

The Royal Surrey County Hospital has traditionally performed well against the national emergency access standard and is achieving around 95.18% for the year to date.

We have commissioned in-reach GPs that will work within the hospital setting, providing a Primary Care view on a patient’s needs and liaising with the patients’ GPs to facilitate non-admission or facilitate discharge.
Table 11: Performance at Royal Surrey County Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>A&amp;E 4 hour Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>95.08%</td>
</tr>
<tr>
<td>2012/13</td>
<td>94.93%</td>
</tr>
<tr>
<td>2013/14</td>
<td>95.08%</td>
</tr>
<tr>
<td>2014/15 YTD</td>
<td>95.18%</td>
</tr>
</tbody>
</table>

Table 12: Attendances at Royal Surrey County Hospital

<table>
<thead>
<tr>
<th>Year (M9)</th>
<th>Attendance</th>
<th>Emergency Admission</th>
<th>Conversion Rate</th>
<th>Length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>69,410</td>
<td>22,054</td>
<td>31.77%</td>
<td>5.53</td>
</tr>
<tr>
<td>2014/15 YTD</td>
<td>54,593</td>
<td>19,348</td>
<td>35.44%</td>
<td>5.34</td>
</tr>
</tbody>
</table>

The Five Year Forward View sets out that there is a need for urgent and emergency care services to be redesigned and emergency services such as A&E departments, GP out-of-hours services, urgent care centres, NHS 111 to integrate where possible. Our Unplanned Care Programme objectives are to support patients to access the right service, first time. Through supporting patients to use Primary Care and community pharmacies for minor ailments will reduce the demand on emergency services. Most people requiring urgent care do not have life threatening problems so we must focus our attention on bringing the best care to people as close to home as possible, wherever they live. When patients have serious problems we must equally ensure they are treated by clinical teams that offer them the best chance of recovery. Seasonal pressures increase demand on A&E departments, Primary Care and the Out of Hours services and in order to ensure that there is resilience in the system we have:

- Examined the emergency care pathway for the G&WCCG area and the RSCH. In particular focusing on the clinical operations within the Accident and Emergency department and making recommendations for programmes for improvement;
- Raised awareness of NHS 111 in Guildford and Waverley through local bus advertisement, local media and press releases, and the installation of a 111 phone at the acute trust to give patients a choice in choosing to call 111 to be signposted to the most appropriate place of care for their medical need.

Throughout 2014/15 we have been working with stakeholders to identify and develop additional schemes that will further enhance and strengthen the emergency systems in order to reduce unnecessary attendances at A&E and enable people in hospital to return home sooner.

The schemes that have been approved for 2015/16 are;
I. **SOS Bus**

Guildford is a University Town and has a high student and young person population with a large number of pubs, clubs, bars and restaurants.

Local data suggests that there are a large proportion of attendances to the A&E Department, Royal Surrey County Hospital for alcohol related causes. Evidence from other areas suggest that many of these attendances could be dealt with differently and without the need of an A&E attendance and deliver the following outcomes:

- Reduce the numbers of people needing to go to A&E on a Friday and Saturday night, possibly Sunday’s over a Bank Holiday and Monday (Student Night) from Guildford’s club/pub land by providing onsite first aid services
- Prevent alcohol related accidental deaths caused as a result of extreme levels of alcoholic intoxication
- Reduce the numbers of people needing to go to Police Stations on a Friday & Saturday night possibly Sunday’s over a Bank Holiday and Monday (Student Night) from Guildford’s club/pub land
- Offer immediate assistance to clients at risk that seek help
- Provide a volunteer run, supportive service, acting as a first point of contact and safe environment for anyone of any age whose well-being is threatened in Guildford’s club/pub land on a Friday and Saturday night possibly Sunday’s over a Bank Holiday and Monday (Student Night)
- Provide a service that is sensitive and responsive to service user's cultural, religious and gender needs.

II. **Winter campaign**

Winter pressure activity has traditionally placed pressure on Acute Trusts and in particular challenged the delivery of emergency care. G&WCCG is working in partnership to plan and maximise resilience to maintain service delivery to patients over the winter period.

Operational resilience funds are now included in the baseline allocation for the CCG and this will provide an opportunity to develop schemes that will support patients in the winter months and reduce the demand of emergency and primary care services. Increasing the levels of Flu vaccination uptake, providing 24/7
psychiatric liaison services within A&E and the development of the 24/7 crisis café, supporting patients to receive the right service, first time will support the local health and social care economy to manage the demand experience during the winter months.

III. Out of Hours Primary Care and A&E Pathway harmonisation

Nationally A&E departments and emergency services are under intense, growing and unsustainable pressure. The two main reasons for the growing pressure on emergency services are an ageing population with increasing complexity of needs, and that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital. Every year patients receive their urgent care needs in hospital which might have been helped closer to home or managed by non-acute service. Attendances at Royal Surrey County Hospital A&E Department which result in no admissions or major treatment have increased, indicating that a number of patients might have been able to be seen and treated in a primary care type setting. A unified self-presentation pathway for A&E and the Out of Hours (OOH) service will:

- Ensure that individuals attending A&E with a minor ailment suitable for OOH GP management are diverted directly to the OOH service
- Reduce presentation in RSCH A&E Departments for primary care type attendances
- Increase uptake and awareness of Out of Hours Service
- Increase and support excellent communications and collaborative working across both providers
- Support RSCH in maintaining the delivery against the 4 hour A&E access target
- Enhance the quality of care provided to patients accessing the emergency care pathway and improve patient experience.
- Bring providers together where appropriate to improve the integration of services for the benefit of patients

IV. Special Alcohol Liaison

Chart 6: Alcohol related admissions

Surrey is a largely affluent county but this apparent prosperity masks areas of real need which can often be neglected and has led to some pockets of marked health inequality. Rates of increasing risk, higher risk and binge drinking among Surrey adults are reflected in the increase in alcohol related admissions.
We have commissioned a hospital based Alcohol Liaison Service that aims to:
- Ensure that patients who are substance users have equal access to essential hospital services and receive the highest standards of care;
- Provide specialist assessment, counselling and health education to hospitalised alcohol users;
- Work in partnership with the Community Drug and Alcohol Team to provide specialist advice on the pharmacological and management of substance users;
- Provide effective communication between the hospital and community based substance misuse services to ensure continuity of care;
- Work in partnership to share best practice and clinical supervision;
- Provide specialist substance misuse education and training to hospital based workers.

V. Rapid Assessment and Treatment in A&E

Minors make up a significant percentage of the total patients attending A&E and therefore the efficient and timely treatment and management of these patients is pivotal to the success of the A&E department. Developing a dedicated space and staff with the expertise to rapidly treat and discharge minors patients can have considerable benefit to the smooth operation of the wider A&E as well as the care of minors.

In addition, there is a strong evidence base that suggests that the average stay in the minors area of the A&E department would be reduced to 81 minutes compared to the current length of time of 135 minutes.

We are working with RSCH A&E department to design a minors area that is ring fenced and treated as a separate stream with Emergency Nurse Practitioners (ENPs) running the area consistently.

Adjusting the patient pathway and realigning responsibilities of nursing staff, in particular, to make the most efficient use of advanced practitioner skills, and improve the see and treat process used for patients presenting with minor conditions will deliver:

- Early assessment of majors patients in A&E
- Defined early care plans for timely decision making
- Early referral or admission decision
- Queues for triage and waits after triage eliminated
- Clinical resources previously tied up in triage can be re-tasked to provide value-adding care
- Unnecessary investigations and tests reduced due to early senior intervention
- Patients identified for admission earlier can leave the department more quickly
- Outcomes and the patient experience are greatly improved
• Improves the resilience of the department to absorb increases in demand and increased ambulance attendances
• Ability to achieve the A&E 4 hour access target is improved
• Improve hospital handover times between RSCH and Secamb
• Support the reduction of unnecessary short stay emergency admissions

VI. Psychiatric Liaison

We are working with Surrey and Borders Partnership NHS Foundation Trust and the RSCH to further develop the hospital based psychiatric liaison services, including for children and young people, that provide mental health care to people being treated for physical health conditions in general hospitals. The co-occurrence of mental and physical health problems is very common among these patients of all ages, often leading to poorer health outcomes and increased health care costs. An effective psychiatry liaison service offers the prospect of saving money as well as improving health and clinical outcomes.

The enhanced services will:

• decrease length of stay for this cohort of patients
• ensure patients receive adequate treatment while using less healthcare resources
• reduce re-admissions and costs
• treat and reduce healthcare costs for patients with ‘unexplained symptoms’
• reduce psychological distress following self-harm and repetition of self-harm

3. Children and Young People Programme

G&WCCG hosts commissioning support for children and young people on behalf of all CCGs in Surrey. In order to ensure that we achieve the ambitions, for children and young people’s health, as set out in the Five Year Forward View we are working with the other Surrey CCGs, NHS England and Surrey County Council to work towards the following priorities for 2015/16 (further detail is available in our Children’s Surreywide Commissioning Intentions 2015/16):

• **Increasing self-management and reducing avoidable use of hospitals.** We will continue to use local radio, advice booklets and targeted parent awareness training. We are working with the South-east Coast Clinical Network to better understand our children’s community nursing workforce and opportunities to further support children with complex needs, including those at end of life, outside of the hospital.

• **Ensuring compliance with the Children and Families Act (2014) regarding children with special educational needs and disabilities (SEND).** Families and stakeholders have helped us review speech and language therapy (SLT), occupational therapy (OT), wheelchair and continence services for children. Contract management of these children’s community services for our patients is hosted by NHS North West Surrey CCG. We have agreed a set of comprehensive joint commissioning principles for SLT with Surrey County Council. As well as effectively aligning our commissioning for best value, these will improve access and reduce waiting times;
focussing CCG investment on earlier assessment and outcome based interventions. In 2015/16 we plan to complete our integration of CCG and local authority joint commissioning for SLT and OT. This will include new service specifications, clinical pathway frameworks and joint key performance indicators. Our providers are working collaboratively with us on this so that they have clarity of purpose and expectation and to enable workforce and clinical pathway redesign as required. We have introduced personal health budgets and a ‘local offer’ of services for children with SEND, clarified commissioning responsibilities for short breaks, reviewed access to continuing healthcare and supported development of partnership frameworks to ensure successful compliance with the Act as we move forward into 2015/16.

- **Improving access to child and adolescent mental health services (CAMHS).** In 2015/16 we reviewed CAMHS services with young people, families, schools and GPs (both as referrers and commissioners). We presented opportunities for improvement to each Governing Body and plan to secure these during 2015/16. We have successfully secured partnership funding to support young people rapidly at times of crisis. In line with the Five Year Forward View the CCG is working closely with NHS England to establish better coordination between CAMHS and Tier 4 services, including age appropriate places of safety for young people with acute Mental Health Needs. This includes children and young people experiencing psychosis, eating disorders and with additional learning disabilities. We have established CQUINs with the CAMHS provider, involving working with acute providers and out of hours emergency services to enhance their knowledge of young peoples’ mental health and improve psychiatric liaison between services. This liaison includes advice and assessment from the community eating disorder service, working with paediatricians and young people who are medically unstable as the demand for tier 4 eating disorder beds has increased. We are emphasising the need for a strong transition between CAMHS and Adult services and this is reflected in our CQUIN and KPIs for the CAMHS service. The psychiatric liaison service will ensure access to our early intervention in psychosis service where required for children and young people admitted to acute care.

- **Improving healthcare for children who are looked after.** This was a key area for improvement in 2014/15, requiring investment and service redesign. This will continue in 2015/16 until we are satisfied new service arrangements are robust and reflected in improved outcomes and key performance indicators.

4. **Mental Health & Learning Disability Programme**

The Five Year Forward View has an ambition to achieve genuine parity of esteem between physical and mental health by 2020. We will commission services that deliver the new waiting time standards so that 75% of people referred for psychological therapies start treatment within six weeks and 95%
start treatment within 18 weeks. Patients experiencing a first episode of psychosis will receive assessment and treatment within 14 days.

Ensuring ‘parity of esteem’, which means that access to, and quality of, mental health services are of equal measure to physical health services, means that further progress is required to deliver this. We will continue to work with Surrey and Borders Partnership Trust to develop an acute mental health pathway that will ensure that Guildford and Waverley patients are able to select which services they receive in line with the agreed provision and standards. This includes children and young people through our CAMHS services and we have redeveloped our Individual funding request pathway for young people to ensure this is robust.

We have been awarded funds to develop a 24/7 crisis café and will work with the Mental Health Connection organisation to develop this in a locally convenient place.

I. **Dementia Care**

Currently we are implementing the dementia data harmonisation project with member practices, through supporting practices to review the data and patient records to identify any patient that has a diagnosis of dementia.

The care of people with dementia is central to all of our plans and in particular the Integrated Care Partnership plans described above. Surrey and Borders Partnership NHS Trust are partners in our BCF Delivery and Implementation Group. However, specifically, we are giving some new and continued focus to two key areas that support our parity of esteem ambitions with regards to people with Dementia.

Dementia Liaison within the hospital and Virtual Wards provision will be extended in to 2015/16 to ensure compatibility and fit with the Integrated Care Partnership implementation. The BCF is continuing to invest in dementia liaison within care homes which will focus on training, education and developing systems and processes within care homes that help plan for contingencies and avoid crises.

In primary care, the CCG continues to make use of the CANTAB assessments to support the increased diagnosis of people with dementia which reflects our commitment to improve this up to 67% by 2017.

To drive the improvement of the dementia diagnosis rate the CCG has developed a recovery plan, approved by our Clinical Commissioning Committee. Working closely with our local GPs and care homes, our Registrar GP will be dedicated to the project for three months. A key element of the process is to engage with care home staff to help to identify where patients are being prescribed drugs for dementia, or where the staff believe that a resident may have dementia, and triangulate this information with the relevant GPs.

Awareness and education are important aspects underpinning the dementia diagnosis rate. Work is currently being undertaken to develop a business case for a primary care based mental health education programme for GPs in
Guildford and Waverley, to ensure that GP’s are appropriately skilled to meet the new challenges.

II. Improving Access to Psychological Therapies (IAPT)

IAPT has seen an increase in the provision of psychological therapies within a primary care setting for people with common mental health problems such as anxiety and depression. There is further work to undertake to increase access to psychological therapies to 15%, which will result in just over 3,000 patients being able to access services for anxiety and depression.

The IAPT referrals have been brought into the referral support service to ensure a greater grip on waiting times and to improve the quality and consistency of referrals. We have increased the number of providers from three to five. We need to consider whether moving to self-referrals would improve access and whether we wish to continue with an Any Qualified Provider model. We do however continue to expect the outcome of a 50% recovery rate, in line with national expectations.

III. Learning Disability

Surrey County Council and G&WCCG have developed integrated commissioning arrangement to determine appropriate packages of care and support, to ensure health and wellbeing needs are met effectively. We will work with the Guildford and Waverley valuing people group to develop a Learning Disability Health Strategy that will focus on the following four priorities:

- Review of Annual Health Checks;
- Review of Health Action Plans;
- Targeted health screening campaigns;
- Learning Disability health strategy to be embedded in commissioning strategies.

This will ensure:

- Individuals with a learning disability are offered person centred care and support planning, through supported self-assessment and offered a personal budget where eligible;
- Individuals with a learning disability enjoy a wider choice of services through ensuring that all providers make reasonable adjustments to facilitate access.

All people with learning disabilities will receive the healthcare and the support they need to live healthy lives. Good health begins with promoting well-being and preventing ill-health, healthy active lifestyles have to be the starting point for all.

Access to the full range of healthcare services including dentistry, screening, sexual health, maternity, health visiting, primary care, hospital care, mental
health care and end-of-life care is essential in ensuring that people with learning disabilities can take greater control of their health and well-being. Key issues are:

- achieving full inclusion of people with learning disabilities in its mainstream work on reducing health inequalities; and
- Ensuring high-quality evidence-based specialist health services.

During 2014/15 we enhanced the provision of Primary Care and Acute Liaison Services to support patients with a learning disability to access primary care annual health checks and the development of health action plans in addition to ensuring that patients are supported to access hospital diagnostic, assessment and treatment services.

5. **Planned Care Programme**

Our planned care programme for 2015-16 is ambitious and will be deliverable as a result of the considerable relationship building we have undertaken with our main acute provider in 2014-15, at many levels - contractual, financial and clinical. We aim to deliver £6.2M of savings though two main programmes:

- **First out-patient appointments at the right time, with the right clinician, only when needed.** This will be achieved through the work of our Referral Support Service (RSS), and through collaborative work with the GP Membership. The RSS now resides within the GP Federation Provider organisation, and is ideally placed for full clinical engagement with its membership. The RSS will work with GPs and our secondary care providers to offer on-going pathway improvement, high quality clinical feedback, and appropriate direction of referrals as clinically needed. This will result in some referrals being managed entirely within primary care, and with increased use of alternatives to face-to-face outpatient attendance such as telephone advice and e-advice services. We will also scrutinise consultant to consultant referrals to ensure these are optimally placed within the referral pathway.

- **Follow-up appointments.** Our clinicians and management teams have met and agreed a joint strategy to rationalise follow-up appointments to address the challenge of the local health economy. We will work with individual clinical directorships within our main provider to scrutinise the follow-up care pathways, seeking to identify existing follow-up pathways as:

  1. Required, to be delivered as currently configured
  2. Required, but with potential for modification to maximise efficiency
  3. Able to be delivered in a different manner, such as telephone or virtual follow-up
  4. Able to be delivered by the patient’s GP under a formal shared arrangement
  5. Not needed, or able to be configured via “as required only” mechanisms
In order to achieve improved outcomes for patients and to manage the levels of demand the following projects will be implemented during 2015/16:

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<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Cardiology</td>
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<td>2.</td>
<td>Gynaecology</td>
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<td>3.</td>
<td>Community Ophthalmology</td>
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<td>4.</td>
<td>DVT pathway</td>
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<td>5.</td>
<td>Anticoagulation</td>
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<td>6.</td>
<td>Totally Health</td>
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<td>7.</td>
<td>End of Life Care</td>
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</tbody>
</table>

I. **Cardiology**

We will redesign the pathway for the management of non-urgent cardiology outpatients where GP's will have direct access to appropriate diagnostics prior to referral to the secondary care team. The patient will be triaged by an appropriate clinician in order for the patient to be placed on the correct pathway and further assessed and treated by the appropriate clinician (GPwSI, nurse specialist, cardiac physiologist) or immediate discharge back to GP with advice and guidance. Utilisation of clinical nurse specialists will ensure only those patients who require consultant input receive it especially in terms of face to face appointments. Follow up appointments will only be undertaken where there is clinical necessity. The Cardiology Consultant Advice and Guidance line is available to primary care physicians to reduce inappropriate referrals and build integration between the primary and secondary care clinicians. The overall aim is to provide a cardiology service in the community where a one-stop shop of services is provided.

II. **Gynaecology**

Across G&WCCG the provision of Gynaecology services has been traditionally delivered by secondary care which has meant women being referred into hospital for assessment, treatment and follow up. During 2014/15 we commissioned a Community Gynaecology Service (CGS) for a limited number of conditions. This has been well received and has reduced waiting times and improved patient experience. The CGS has worked with the Gynaecology Consultants and where a surgical procedure is required the patient can be placed straight on to the consultant list, reducing the need for a new patient appointment prior to the procedure.

The CGS project will expand during 2015/16. They are currently triaging all referrals on behalf of the Referral Support Service and will increase service provision to enable them to receive a wider range of gynaecological condition referrals during 2015/16.

III. **Community Ophthalmology**

The provision of Ophthalmology services has been traditionally delivered within secondary care which has meant patients being referred into hospital for assessment, treatment and follow up. It is widely felt that in a large proportion
of these cases all of the above interventions could be undertaken at one appointment with an accredited Optometrist within a community setting. During 2014/15 we commissioned a number of community optometrist to receive referrals for the following conditions;

- Acute eye scheme direct referral
- Wet AMD service
- Stable glaucoma monitoring
- Pre & post-operative cataract care service

The Community Ophthalmology Service will:

- Provide care and consultation relating to specific Ophthalmic conditions/presentations
- Ensure patients are seen by an Optometrists as opposed to consultants in secondary care wherever possible
- For Optometrists to provide this care at reduced cost
- Ensure patients are seen more quickly and closer to their homes with choice of provider
- Provide a service which when measured provides evidence of good patient satisfaction
- Provides electronic communication in a timely fashion with practices

Three of the four pathways have been successfully commissioned and the final pathway of Acute Eye scheme direct referral is due to commence early in 2015/16.

IV. Deep Vein Thrombosis pathway

There is scope to redesign the existing DVT pathway, which can currently involve long waiting times in A&E for the patient and multiple visits to the hospital. This is a costly model and there is good evidence from other CCG areas that streamlined one-stop models have been implemented within the community at reduced tariff.

We will commission a fully functioning and clinically sound comprehensive DVT assessment and treatment service which is one-stop to ensure the patients of Guildford and Waverley receive a gold standard service not based in A&E.

V. Anticoagulation

Practices in Guildford and Waverley are commissioned to provide anticoagulation services within the community which means that secondary care services are reserved for patients with complex conditions that are excluded from management in Primary Care.

NICE have published new guidance relating to new oral anticoagulants which do not require regular monitoring. The new oral anticoagulants can be initiated and prescribed in Primary Care without a dedicated monitoring service. This will impact on the commissioning of anticoagulation services at local level.
VI. **Totally Health**

Totally Health is a tele-coaching service that provides innovative Long Term Conditions Management solutions to transform behaviour to achieve better health outcomes for patients with long term conditions. This in turn reduces emergency admissions to secondary care. Empowering patients to self-care in the community will result in a better quality of life for patients, improved condition outcomes, and a reduction in inappropriate A&E attendances and savings for the CCG.

VII. **End of Life Care**

We have recently convened an End of Life Strategy Group that is working towards developing joined up and integrated high quality safe care that meets the needs of patients.

The CCG has identified End of Life Care as a key clinical priority for 2015/16. We are dedicated to raising the profile of End of Life Care within our locality in an effort to remove any negative stigma associated to dying and death, and to assist in enabling patients to discuss with clinicians what constitutes a ‘good death’ for them. This will be achieved through continuous stakeholder engagement and events to discuss End of Life Care, thereby embedding the needs of End of Life patients into the consciousness of clinicians and health and social care providers; and through engagement with the Dying Matters coalition and our local Health & Wellbeing Board to adjust public perception of death and dying.

As part of the CCG’s commissioning intentions for 2015/16 we will be assessing the current provision of End of Life Care within our locality in an effort to review the need for rapid access to care, including appropriately trained staff and
equipment needs, 24 hours a day, 7 days a week. Once gaps and/or inequity of service provision have been identified we aim to ensure these can be addressed so that unnecessary hospital admissions are avoided and more people are able to live and die in their preferred place of care.

6. Medicines Management

Medicines optimisation supports cost-effective prescribing in primary care, as well as helping patients to manage their medications better. Good medicines optimisation can help reduce the likelihood of medication errors and patient harm. Adverse drug reactions can lead to hospital admission, particularly among vulnerable groups such as frail older people. In addition, poor compliance with medicines prescribed for long term conditions can lead to poorer outcomes and significant waste. Priorities for medicines management include:

- Medication reviews and systematic support to improve compliance and reduce wastage;
- Implementation of the Prescribing Clinical Network decisions;
- Effective systems to manage medication across primary-secondary care interfaces, including working towards sending prescriptions electronically;
- Improved communication to enable safe transfer of information about patient medication at admission and discharge;
- Review of oral nutritional supplements and community dietetic services.
- Reduction in the use of specials particularly when licensed alternatives are available.
- Support the reduction of waste through the “Not Dispensed Scheme”.
- Improving access to repeat medicines in the out of hour’s period.
- Ensure the appropriate use of antibiotics
- Implementation of NICE TAs in relation to medicines

4.5.13 Operational Delivery Key Milestones

Table 13: Milestones 2015/16

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<tbody>
<tr>
<td>Unplanned Care</td>
<td>SOS Bus mobilisation Out of Hours Primary Care Co-location with A&amp;E</td>
<td>Implement the recommendations from the Emergency Service Review</td>
<td>Review progress and evaluate impact Winter campaign</td>
<td>Plan service transformation 2016</td>
</tr>
<tr>
<td>Mental Health &amp; Learning Disability</td>
<td>Establish IAPT recovery plan Review current LD provision</td>
<td>Mobile Crisis Café Learning Disability Health Strategy</td>
<td>Review progress and evaluate impact and patient experience</td>
<td>Plan service transformation 2016</td>
</tr>
<tr>
<td>Planned Care</td>
<td>Establish ‘Planned Care Hospital Implementation Group’ to oversee clinical delivery of the Planned Care programme – Chaired by the CCG</td>
<td>Anticoagulation Ophthalmology End of Life Strategy Delivery Plan</td>
<td>Review progress and evaluate impact and patient experience</td>
<td>Plan service transformation 2016</td>
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</tr>
<tr>
<td>Planned Care Clinical Lead, senior representation from Acute provider clinical body – acts as project liaison and co-ordination around individual Clinical Directorships workstreams. End of Life Strategy</td>
<td></td>
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<tr>
<td>Medicine Management</td>
<td>Appoint to substantive posts to continue delivery of medication reviews post pilot phase.</td>
<td>Agree Local Prescribing Scheme with GP practices Re- negotiation of existing rebates</td>
<td>Review progress and evaluate impact and patient experience</td>
<td>Plan service transformation for 2016 based on review of successes</td>
</tr>
</tbody>
</table>
5.0 ACCESS

5.1 Convenient Access for Everyone

Convenient access to required health care is an important determinant of health outcomes. The CCG has developed equality analysis processes and procedures and mainstreamed these into core business units to ensure that access is considered for all equality groups and vulnerable communities whenever decisions are made. The CCG will focus on improving access to:

- primary care
- locally-organised multidisciplinary care for the frail and vulnerable
- mental and physical health care for people suffering with acute mental illness
- the right care at the right time through alternative models of elective care that utilises a greater skill mix
- support for people with learning disabilities that ensures they benefit from routine care to the same extent, or better, than patients without learning disabilities
- earlier diagnosis for patients with cancer
- a range of maternity services
- CAMHS to provide alternative appointments including services within the gypsy roma traveller community and extend the opening times of CAMHs clinics

5.2 Primary Care

The CCG welcomed a recent Healthwatch Surrey survey that asked people in Surrey about their experiences of booking an appointment with their GP practice. The information provided has been incorporated into primary care liaison plans for 2015/16.

The CCG will continue to meet practice managers to share best practice in terms of the use of current booking mechanisms e.g. online booking; more telephone lines available during peak times and availability at lunchtime; use of nurse triage and telephone appointments. In addition, practices are being encouraged to use SMS text reminder systems to ensure appointments are not wasted, to the benefit of other patients that need to see a GP.

A campaign to help patients get the most from their GP appointment will be promoted.

Special provision is available for babies and young children, elderly patients and those with complex health needs. Same day appointments for these patients are a seen as a priority.

The CCG will run another campaign in quarter 3 of 2015/16 to promote use of 111 and community pharmacists. This will build upon a successful 2014/15 campaign to protect specialists for people with complex and acute health needs whilst steering the public to make more use of conveniently positioned community pharmacists and the telephone advice of NHS 111.
14 practices currently offer extended hours through the Direct Enhanced Service (DES), two more than the previous year. The CCG will encourage all practices to sign up to the extended hours DES in 2015/16 to offer services outside core hours and thus reduce pressure during normal opening times, leading to a better experience for all.

GPs have increased the number of visits to care homes, which has improved relationships and improved access to the available GP.

We encourage the further development of IT based solutions to facilitate this, whilst appreciating that a range of access solutions is needed.

Patient Participation Groups (PPGs) are well positioned to facilitate the dialogue between patients and practices at local level. The CCG will continue to support PPG chairs to carry out this role via quarterly network meetings and bi-monthly newsletters in 2015/16, as detailed in the Communications and Engagement Strategy 2014-16.

5.3 Crisis Care and Acute Liaison

Working together with partners across the system, the CCG is developing a safe haven in the form of a crisis café for patients with mental health needs. Initial meetings have taken place with plans for future, monthly meetings of key partners. Discussions are currently underway to help identify a location and the appropriate staff members.

Partners are looking to enable whole system change which will significantly improve outcomes for vulnerable people in crisis situations. The facility will provide an out of hours’ service for people in need and will have significant benefits for people with mental health issues and their carers, ensuring parity of esteem with people with physical health issues.

We will focus on prevention and early intervention, educating people to utilise peer support groups and safe havens in their local area rather than escalating distress into a crisis which ends up in accident and emergency services. This focus on public awareness and vulnerable people managing their own crisis will reduce service demand and promote personal resilience.

5.4 Cancer

The CCG’s vision for cancer is for:

- people to be empowered to reduce their risk of developing cancer with greater awareness of cancer prevention
- people to receive earlier diagnosis of cancer by access to effective screening programmes, timely referral and investigations
- people with cancer to receive good, co-ordinated care and, post treatment, receive education and on-going support to improve their well being
- outcomes and survival rates to improve for cancer patients in Guildford & Waverley
In January 2015, NHS England announced the establishment of an independent taskforce to develop a five-year strategy for cancer services. The taskforce is charged with delivering the vision set out in the NHS Five Year Forward View. It will consider prevention, first contact with services, diagnosis, treatment, support for those living with and beyond cancer, end-of-life care and the research environment. The strategy will also cover how services will need to develop and innovate in the future. The finalised strategy is due to be published in summer 2015.

The CCG will be working with stakeholders to deliver the national strategy locally through the multi-agency Cancer Strategy Steering Group. This Group reports to the G&WCCG End of Life Care and Cancer Sub Group, which is a sub-committee of the G&WCCG Clinical Commissioning Committee. We will be actively monitoring cancer performance, including cancer survival rates, at our End of Life Care and Cancer Sub Group through our Cancer dashboard.

5.5 **Maternity Services**

The Five Year Forward view confirmed that NHS England will commission a review of future models for maternity units, we will work with women and their partners to ensure that the recommendations published are fully implemented.

Women in our local area have options to deliver within a consultant led unit, co-located midwifery led units; a stand-alone birth centre or at home. These choices will be guided by the mother’s wishes and their individual clinical needs. They can also choose between different providers.

Following investment, the maternity service at our main acute trust, the RSCH, now offers a choice of birthing arrangements, including the provision of a birthing pool for women at high risk, e.g. bariatric and disabled women, and a dedicated home birth team.

During 2015-16 the Trust is planning the development of 4 maternity ‘nests’. These will be based on the antenatal ward, enabling parents who have travelled a long distance in early labour but are not ready for a labour ward room but aren’t keen to travel home, to have somewhere ‘home from home’ to relax and let their labour progress naturally.

5.6 **Access to regular repeat prescriptions in the out of hours (OOH) period**

The CCG will continue working with 111, Care UK, Local Pharmaceutical Committee and the Local Pharmacy Network to improve the access to repeat prescriptions in the OOH period. This work focuses on improving repeat prescribing processes in GP practices and working with 111 to direct patients to their community pharmacy in the first instance that may be able to help through the provision of the “Emergency Supply” service, which is currently a non-NHS service.

The CCG will look at ways that this service could be commissioned as a NHS service through community pharmacies.
5.7 Meeting the NHS Constitution Standards

The CCG will achieve the NHS Constitution standards through a variety of measures. We continue to work with our partners to ensure that patients can expect to wait no longer than is set out in the Constitution which is detailed below.

Table 14: Royal Surrey County Hospital

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>RAG</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
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<tbody>
<tr>
<td>HCAI</td>
<td>[RSCH] - C. difficile infections (Apportioned to Acute Trust)</td>
<td>23</td>
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<tr>
<td></td>
<td>[RSCH] - MRSA Bactereamia (Apportioned to Acute Trust)</td>
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<tr>
<td>RTT - Referral To Treatment</td>
<td>[RSCH] - RTT Admitted Patients (RTT within 18 weeks)</td>
<td>90</td>
<td>G</td>
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<td></td>
<td>[RSCH] - RTT Incomplete Patients (RTT within 18 weeks)</td>
<td>92</td>
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<td></td>
<td>[RSCH] - RTT Non Admitted Patients (RTT within 18 weeks)</td>
<td>95</td>
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<tr>
<td></td>
<td>[RSCH] - Number of Patients Waiting More Than 52 Weeks</td>
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<td>DM01 - Monthly Diagnostics</td>
<td>[RSCH] - DM01 Diagnostic Waiting Times (Within 6 weeks)</td>
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<td>[RSCH] - Cancer Waits: 62 Days from Urgent GP referrals</td>
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<td><strong>A&amp;E Monthly Performance</strong></td>
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<td>[RSCH] - A&amp;E Monthly Performance</td>
<td>95</td>
<td>R</td>
<td>96.64</td>
<td>95.01</td>
<td>95.78</td>
</tr>
<tr>
<td><strong>Ambulance Handovers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[RSCH] - All handovers between ambulance and A&amp;E must take place within 15 minutes with none taking over 15 minutes</td>
<td>0</td>
<td>R</td>
<td>1627</td>
<td>1155</td>
<td>1200</td>
</tr>
<tr>
<td>[RSCH] - All handovers between ambulance and A&amp;E must take place within 15 minutes with none taking over 30 minutes</td>
<td>0</td>
<td>R</td>
<td>382</td>
<td>200</td>
<td>166</td>
</tr>
<tr>
<td>[RSCH] - All handovers between ambulance and A&amp;E must take place within 15 minutes with none taking over 60 minutes</td>
<td>0</td>
<td>R</td>
<td>45</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td><strong>Cancelled Operations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[RSCH] - Cancelled Operations</td>
<td>0</td>
<td>R</td>
<td>16</td>
<td>12</td>
<td>18</td>
</tr>
</tbody>
</table>

### Table 15: SECAmb Performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>RAG</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>[SECAMB] - Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)</td>
<td>75</td>
<td>G</td>
<td>75.25</td>
<td>75.26</td>
<td>73.79</td>
</tr>
<tr>
<td>[SECAMB] - Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)</td>
<td>75</td>
<td>G</td>
<td>74.80</td>
<td>73.12</td>
<td>73.61</td>
</tr>
<tr>
<td>[SECAMB] - Category A calls resulting in an ambulance arriving at the scene within 19 minutes (R1+R2)</td>
<td>95</td>
<td>G</td>
<td>97.07</td>
<td>96.57</td>
<td>96.86</td>
</tr>
</tbody>
</table>

### Table 16: Guildford & Waverley CCG

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>RAG</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCAI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - C. difficile infections (Apportioned to Acute Trust)</td>
<td>29</td>
<td>G</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>[G&amp;WCCG] - MRSA Bactereamia (Apportioned to Acute Trust)</td>
<td>0</td>
<td>R</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>RTT - Referral To Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - RTT Admitted Patients (RTT within 18 weeks)</td>
<td>90</td>
<td>A</td>
<td>85.83</td>
<td>88.92</td>
<td>88.22</td>
</tr>
<tr>
<td>[G&amp;WCCG] - RTT Incomplete Patients (RTT within 18 weeks)</td>
<td>92</td>
<td>G</td>
<td>93.82</td>
<td>94.59</td>
<td>93.56</td>
</tr>
<tr>
<td>Metric</td>
<td>Target</td>
<td>RAG</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>[G&amp;WCCG] - RTT Non Admitted Patients (RTT within 18 weeks)</td>
<td>95</td>
<td>G</td>
<td>97.68</td>
<td>96.54</td>
<td>96.11</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Number of Patients Waiting More Than 52 Weeks</td>
<td>0</td>
<td>R</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>DM01 - Monthly Diagnostics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - DM01 Diagnostic Waiting Times (Within 6 weeks)</td>
<td>99</td>
<td>A</td>
<td>99.49</td>
<td>96.71</td>
<td>98.71</td>
</tr>
<tr>
<td><strong>Cancer Waits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 2 Week Rule (Urgent GP Referral)</td>
<td>93</td>
<td>A</td>
<td>96.06</td>
<td>96.24</td>
<td>93.79</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 2 Week Wait (Exhibited Non-Cancer Breast Symptoms)</td>
<td>93</td>
<td>G</td>
<td>76.16</td>
<td>94.26</td>
<td>95.26</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 31 Days to subsequent Treatment (Drugs)</td>
<td>98</td>
<td>G</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 31 Days to subsequent Treatment (First Treatment)</td>
<td>97</td>
<td>G</td>
<td>97.98</td>
<td>98.78</td>
<td>100.00</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 31 Days to subsequent Treatment (Radiotherapy)</td>
<td>94</td>
<td>G</td>
<td>93.42</td>
<td>95.65</td>
<td>96.20</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 31 Days to subsequent Treatment (Surgery)</td>
<td>94</td>
<td>G</td>
<td>96.72</td>
<td>94.23</td>
<td>98.15</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 62 Days from Screening service referral</td>
<td>90</td>
<td>G</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>[G&amp;WCCG] - Cancer Waits: 62 Days from Urgent GP referrals</td>
<td>85</td>
<td>G</td>
<td>97.37</td>
<td>96.97</td>
<td>95.52</td>
</tr>
<tr>
<td><strong>MSA - Mixed Sex Accommodation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - Mixed Sex Accommodation (MSA)</td>
<td>0</td>
<td>G</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mental Health - Care Program Approach</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[G&amp;WCCG] - Care Programme Approach (CPA)</td>
<td>95</td>
<td>G</td>
<td>97.37</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

5.8 The development of the Referral Support Service (RSS) will be geared to ensuring that patients have access to the right pathways and clinics within the timescales set out in the Constitution. The RSS will work with GPs to maximise the use of Choose and Book, working towards the 80% of GP referrals to be sent electronically to providers by 31st March 2016.

5.9 For A&E waits we are working closely with the members of our Systems Resilience Group (SRG) in order to identify and address any key blockages in the system. The key focus for this standard lies with the Acute Trust. The CCG and the Acute have worked together to develop a joint action plan to bring about the implementation of a true Rapid Assessment and Treatment (RAT) pathway for patients who present at A&E. Two key components of this are the rapid triage of all patients within 15 minutes. This applies equally to patients who walk in or are conveyed by ambulance to the Emergency department. The second key
component is the development of a treatment plan, including the option to discharge, for all patients within two hours.

5.10 Ambulance handover times have not been achieved in previous years. Going forward, SECAmb will be looking to implement an immediate handover policy with Acute providers. There are a number of risks relating to this policy and these need to be understood and managed prior to full implementation.

5.11 SECAmb are also reviewing their allocation of funding to Community First Responders to ensure that their signed up, trained volunteers are currently active and participating towards achieving the relevant targets. The CCG are working closely with SECAmb on this and will be aiming to implement any recommendations that emerge from the review.

5.12 With regards to the 6 week wait for diagnostics, the CCG have worked with our acute partner on a number of RESET initiatives and one of the outcomes has been the introduction of seven day services for the imaging department. This will be instrumental in achieving the 6 week wait in coming years.

5.13 Delivery of the Referral to Treatment target for admitted patients has been an issue for the CCG and its main provider Royal Surrey Country Hospital, throughout 2014/15. Whilst significant attention and focus has been maintained, supported by the deployment of additional funding, overall achievement has continued to be below the expected levels.

Following a review by Ashford and St Peters as part of the merger discussions, it was identified that the way RSCH was applying the rules for reporting activity centrally was not consistent with their peers. Upon discovery the Trust immediately requested the support of NHS IMAS, which was provided.

The work that has been taking place with the support of NHS IMAS identified that the reporting rules that RSCH use needed to be amended and an action plan to address this was instigated. Additionally external validation has been taking place to ensure that patients are appropriately placed on the waiting list and that patient safety hasn’t been compromised.

The initial phase of work has been completed and a detailed recovery plan is being developed by RSCH, with the support of the NHS IMAS. Whilst this is not available at the time of writing, the CCG have been actively involved in the discussions. The outcome of the recovery plan being developed is that Non-admitted and Incomplete performance, although dipping, will remain above the threshold. The full impact on the admitted pathway is not known at this stage but both the Trust and CCG are expecting that overall performance will be achieved.

The CCG will be attending the weekly PTL review meeting held by the Trust, in addition to a monthly assurance meeting that is being established to monitor delivery, which will be attended by senior representation of both organisations. The escalation route for performance concerns will be through the monthly formal contract management meetings.

5.14 All of the CCG’s QIPP schemes aim to deliver increased performance against all of the NHS Constitution measures, as well as improving patient outcomes and
experience, thereby also linking to the NHS Outcomes framework. The planned reduction of A&E attendances, combined with internal improvements of the urgent care system and collaborative systems resilience across all healthcare providers, will improve performance delivery against the 4hr target. In particular, the CCG has put significant pressure on the acute provider to ensure that triage times are significantly reduced. In addition, the urgent care pathway improvements, plus increased primary care proactive management of patients through locality MDT meetings, will reduce emergency admissions. This will free up valuable bed stock in order to deliver increased elective and day case activity. The CCG will be working very closely with its primary care clinicians which, when combined with the enhanced referral support system, will deliver reduced referrals through to acute providers and redirection of a large percentage of this activity to a variety of community service providers that will act as a ‘one-stop shop’ without the need to have subsequent follow-ups. The majority of community service providers have the capacity to increase activity and deliver significantly improved waiting times standards than what have been typically seen through the acute providers. To enhance RTT delivery further, a number of schemes which affect some of the top 18-week pathway challenges (e.g. T&O) will be enhanced further over 2015-16 to triage more patients and more rapidly direct them to the most appropriate care pathway. This will have the knock-on impact of reducing consultant led activity, which can be more focused and timely for patients
6.0 QUALITY

6.1 The CCG has a legal duty to improve the quality of services commissioned and to effectively discharge the duty for quality; the Governing Body has delegated authority to the Quality and Clinical Governance Committee who have worked to their designated work plan.

6.2 Under the leadership of the Executive Nurse, Director of Quality and Safeguarding, a number of activities are performed regularly to address quality. This includes: monthly meetings with other Surrey CCG Quality and Nursing leads; attendance at Quality Surveillance Group (QSG); Quality and Clinical Governance Committee meetings; Clinical Quality Review (CQR) meetings with commissioned services; attendance at other CCG CQR meetings with services which affect G&WCCG’s local population and Serious Incident Sub-Committee meetings with a specific focus on the scrutiny of serious incident investigations.

6.3 Over 300 quality metrics are routinely monitored and escalated as required. These all fall within the patient safety, clinical effectiveness or experience domain of the NHS Quality Framework or they concern the access and flow of patients into a particular healthcare service.

6.4 The CCG are particularly pleased with the performance of a range of quality metrics in commissioned services. These include: low rates of Clostridium difficile; implementation of the care programme approach for patients with mental illness; rates of Methicillin Resistant Staphylococci Aureus (MRSA) Bactereamia infection; decrease in mortality rates (actual and indexed); high satisfaction levels with maternity services and day cases; improved Ambulance response times for urgent calls requiring attendance within 8 minutes.

6.5 G&WCCG recognise that there are a number of challenging performance areas which require on-going collaborative focus. These include: Mixed Sex Accommodation Breaches; Cancer wait times; Accident and Emergency services Four Hour Wait; Pressure Damage Reduction and anticipatory care planning. The plans that are detailed below address these areas.

6.6 Response to Francis, Berwick and Winterbourne View

The Francis and Berwick Reports have made a significant impact on the approach the CCG’s have in their statutory obligation of securing and continually improving quality in the services they commission – particularly as the Commissioners were identified as having a key part to play in past failures.

The CCG have made public declarations on their website around the commitment to these reports. Furthermore, in 2014, the Governing Body held a half day organisational development session focusing on the implications of the reports and gave senior management the opportunity to identify what further actions are required.

The actions were subsequently incorporated into the 2014/16 quality strategy which was approved at a Governing Body meeting in public, and work on many of the plans are underway. These will be completed in 2015/16 and will be governed by the Quality and Clinical Governance Committee. They are as
follows (and exclude patient safety plans which are covered in a later section of this document):

Table 17: Quality Strategy

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To Possess Robust Quality Information</strong></td>
<td>Completion of the automation of the quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Develop statistical process control methods for accurate assessment of quality standards</td>
</tr>
<tr>
<td></td>
<td>Develop and report on early warning system based on high-level indicators</td>
</tr>
<tr>
<td></td>
<td>Development of the quality portal for General Practice and connectivity to quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Development of the patient engagement strategy and systems of feeding quality Information into quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Systematic scoping of ‘quality’ information in the media and systems to feed into the quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Expand and encourage access to quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Review comprehensiveness of quality dashboard including the identification of quality metrics for workforce (e.g. staff satisfaction, safe staffing levels), measurement of health inequalities, ad-hoc concerns/complaints, findings of CQC inspections and intelligence reports and data pertaining to the NHS Outcomes Framework</td>
</tr>
<tr>
<td></td>
<td>Develop systematic feed of quality Information from provider meetings focusing on specific improvements (e.g. Accident and Emergency, Ophthalmology, Mortality) to quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Further develop the triangulation of data to ensure an accurate portray of quality levels</td>
</tr>
<tr>
<td></td>
<td>To develop a robust process of capturing and reporting on feedback from patients and the public onto the quality dashboard</td>
</tr>
<tr>
<td><strong>To Report and Monitor Quality Information</strong></td>
<td>To enhance the Governing Body report</td>
</tr>
<tr>
<td></td>
<td>To develop system of reporting to Clinical Commissioning Committee</td>
</tr>
<tr>
<td></td>
<td>To develop robust system of sharing quality reports with neighbouring CCGs</td>
</tr>
<tr>
<td></td>
<td>To consider quality updates via the CCG website</td>
</tr>
<tr>
<td></td>
<td>To develop robust systems of reporting quality Information to General Practitioners</td>
</tr>
<tr>
<td><strong>To Prevent Sub-Optimal Quality</strong></td>
<td>To develop a schedule of regular clinical visits over a year</td>
</tr>
<tr>
<td></td>
<td>To develop a systematic feedback of quality Information from regular clinical visits to the quality dashboard</td>
</tr>
<tr>
<td></td>
<td>To raise awareness with Clinical Commissioning Team of feedback from walkabouts of commissioned services to Quality dashboard and Quality/Safeguarding team.</td>
</tr>
<tr>
<td></td>
<td>To review effectiveness of Clinical Quality Review Meetings</td>
</tr>
<tr>
<td>Strategic Goal</td>
<td>Plans</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>To develop a feedback loop of decisions taken at Integrated Performance Committee to Quality and Clinical Governance Committee</td>
</tr>
<tr>
<td></td>
<td>To ensure that for all quality concerns there are clear lines of accountability, and the responsible individuals are requested to discuss quality and assurances at the Clinical Quality Review meetings held with Commissioned Services</td>
</tr>
<tr>
<td></td>
<td>To ensure that the CCG approve workforce reviews that are required for Health Education Kent Surrey and Sussex</td>
</tr>
<tr>
<td>To Establish Expectations of</td>
<td>To establish formalised processes for the identification of local quality schedules and incentives based on existing risk profiles of providers</td>
</tr>
<tr>
<td>Quality</td>
<td>To establish formalised data returns on quality schedules and ensure implementation within the quality dashboard</td>
</tr>
<tr>
<td></td>
<td>To consider and develop an integrated contractual performance and quality report covering both national and local schedules as well as additional information not directly covered by the contract</td>
</tr>
<tr>
<td></td>
<td>To establish more formalised methods of identification and CQUIN payment schemes through the Working Group of the Quality and Governance Committee</td>
</tr>
<tr>
<td></td>
<td>To ensure the selection of CQUIN payment schemes utilise a range of data resources including patient and public feedback and findings of reviews (e.g., emergency and urgent care)</td>
</tr>
<tr>
<td></td>
<td>To ensure that the CQUIN Payment is in line with what is recommended from NHS England (e.g., 2.5% of contract value)</td>
</tr>
<tr>
<td></td>
<td>To establish system of benchmarking quality information for new bids/tenders to enable an accurate and reliable method of establishing standards of quality</td>
</tr>
<tr>
<td></td>
<td>To incorporate the selection of local quality schedules, incentives, and CQUIN local payment schemes into the patient engagement strategy</td>
</tr>
<tr>
<td></td>
<td>To develop a formalised information return for CQUIN schemes</td>
</tr>
<tr>
<td></td>
<td>To review performance and take decision on compliance to both CQUIN and QP schemes</td>
</tr>
<tr>
<td></td>
<td>To establish a formalised process of returning quality information from the service outcome reviews into the quality dashboard</td>
</tr>
<tr>
<td></td>
<td>To establish a formalised process of acting on sub-optimal quality information from the service outcome reviews.</td>
</tr>
<tr>
<td>To Reward Quality</td>
<td>To develop a schedule of media coverage celebrating good/excellent quality in commissioned services</td>
</tr>
<tr>
<td></td>
<td>To develop, in all formal meetings with commissioned services, an opportunity to celebrate key successes in quality</td>
</tr>
</tbody>
</table>
### Strategic Goal

<table>
<thead>
<tr>
<th>Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>To feedback via the Quality report, discussions and decisions from Quality Leads Meetings</td>
</tr>
<tr>
<td>To contribute to the organisation of the Nursing Conference for Surrey and North East Hampshire and Farnham</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Work Collaboratively To Achieve System Wide Quality Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope participation in strategic clinical networks and ensure NHS G&amp;WCCG involvement</td>
</tr>
<tr>
<td>Application for Patient Safety Fellow through the Patient Safety Collaborative</td>
</tr>
<tr>
<td>To host six monthly serious incident learning events for Surrey and North East Hampshire and Farnham</td>
</tr>
</tbody>
</table>

6.7 In November 2014 NHS England published an independent report into the future care of people with learning disabilities. Sir Stephen Bubb, Chief Executive of charity leaders body ACEVO, was asked by NHS England to work with stakeholders and make recommendations for the development of a national commissioning framework to address the serious shortcomings in the provision of support for people with learning disabilities.

6.8 Sir Stephen chaired an independent group who developed the report, “Winterbourne View – Time for Change”, with guidance and expertise from healthcare professionals, the voluntary sector, local government and people with learning disabilities, their families and carers.

6.9 Sir Stephen’s report makes a series of recommendations for the NHS, local government, regulators and the government, that include a robust NHS commissioning framework to support people with learning disabilities and autism move out of hospitals and into the community.

6.10 The report sets out ten recommendations that include:

- the introduction of a Charter of Rights for people with learning disabilities and/or autism and their families;
- giving people with learning disabilities and their families a ‘right to challenge’ decisions and the right to request a personal budget;
- a requirement for local decision-makers to follow a mandatory framework that sets out who is responsible, for which services and how they will be held to account, including improved data collection and publication;
- a planned closure programme of inappropriate institutional in-patient facilities supporting patient choice;
- improved training and education for NHS, local government and provider staff; and
- the founding of a social investment fund to build capacity in community-based services.

6.11 NHS commissioning arrangements within Surrey have delegated responsibility for the local implementation of the Winterbourne View agenda to the Healthcare Planning Team at NHS Surrey Downs CCG. The Health Care Planning Team Board has been established to ensure the work plan is focused and delivering on
its aims and objectives. It meets quarterly. Membership is from health, social care and other provider organisations. A person with learning disabilities is co-chair and a family representative is a core member. G&WCCG are represented at this meeting by the Designated Nurse for Safeguarding Adults. Additionally the G&WCCG Executive Nurse, Director of Quality and Safeguarding is a member of the Transforming Care Programme Board (South) and has senior oversight of developments in care standards for people living with learning disabilities.

6.12 A significant amount of work has been undertaken by the Healthcare Planning Team during 2014/15 to ensure that Guildford and Waverley patients receiving care in Assessment & Treatment centres have received regular care reviews and timely discharge planning into appropriate community settings.

6.13 Assurances have been provided by the Healthcare Planning team that all patients transferred from Assessment and Treatment centres will continue to receive their support to ensure the transition from hospital to home is made as smoothly and risk free as possible.

6.14 G&WCCG is committed to contributing to the national Winterbourne View Joint Improvement Programme and continues to work closely with local and national stakeholders including NHS England, local authorities, health care planners and service users to ensure the recommendations of the Bubb Report lead to improved outcomes for people with learning disabilities.

The plans for 2015/16 are as follows:

- G&WCCG to continue working with key stakeholders within the Winterbourne View Joint Improvement Programme
- G&WCCG to continue to have strategic oversight of developments via the Transforming Care Programme Board (South) and ensure that these are translated in to the Surrey wide strategic commissioning plans for people with learning disability
- G&WCCG to work jointly with the Healthcare Planning Team to ensure that patients transferred from Assessment and Treatment centres will continue to receive their support to ensure the transition from hospital to home is made as smoothly and risk free as possible.

6.15 G&WCCG Learning Disability Commissioning Manager to work closely with local acute hospital, community LD Liaison Staff and Community team for People with Learning Disability teams to prevent unnecessary hospital admission.

6.16 Patient Safety

In addition to the work the CCG has done to address the recommendations in the Berwick report, they also provide an in-house (rather than Commissioned Support Unit) patient safety service for serious incidents that occur within commissioned services. The responsibilities for patient safety are through the Serious Incident Sub-Committee who are a sub-group of the Quality and Clinical Governance Committee. The sub-Committee has functioned since 1st April 2014 and has reviewed and closed a number of serious incidents as well as
considered the rates, types and grades of harm across a range of services and made recommendations as required. Their plans for 2015/16 are as follows:

Table 18: Patient safety

<table>
<thead>
<tr>
<th>Theme</th>
<th>Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>To understand and measure harm in commissioned services</td>
<td>To further develop robust processes for the capturing and reporting of trends in serious incidents</td>
</tr>
<tr>
<td></td>
<td>Enhance the serious incident monthly reports to enable more detailed understanding of serious incidents</td>
</tr>
<tr>
<td></td>
<td>Review a quarterly thematic analysis of serious incidents and action closure produced by Commissioned services</td>
</tr>
<tr>
<td></td>
<td>Further develop the triangulation of data to ensure an accurate portray of safety</td>
</tr>
<tr>
<td></td>
<td>Encourage the reporting of incidents and serious incident in Primary care and establish feedback loop from Area Team</td>
</tr>
<tr>
<td>To support the development of capacity and capability in patient safety improvement</td>
<td>Develop systems for correlation of sub-optimal areas of quality with the risk register</td>
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<tr>
<td></td>
<td>To host the Surrey wide Learning From Serious Incident Event</td>
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<tr>
<td></td>
<td>Scope participation in strategic clinical networks and ensure NHS G&amp;WCCG involvement</td>
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<tr>
<td></td>
<td>Application for Patient Safety Fellow through the Patient Safety Collaborative</td>
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<tr>
<td></td>
<td>To host six monthly serious incident learning events for Surrey and North East Hampshire and Farnham</td>
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<td></td>
<td>Create a Patient Safety and Quality Officer role to support all patient safety initiatives</td>
</tr>
<tr>
<td>Increase reporting of harm to patients</td>
<td>Development of the quality portal for General Practice and connectivity to quality dashboard</td>
</tr>
<tr>
<td></td>
<td>Encourage the reporting of incidents and serious incident in Primary care and establish feedback loop from Area Team</td>
</tr>
<tr>
<td></td>
<td>Review benchmarked data of commissioned services and request deep dives into reporting as required</td>
</tr>
</tbody>
</table>

6.17 There are additional areas of patient safety that nationally are considered emerging priorities and, as such, will feature as priorities for G&WCCG. These specifically are for the acute commissioned services and involve the management of sepsis and the reduction of acute kidney injury.

6.18 The table below sets out the plans for both areas. It should also be noted that some form part of the national quality schemes of the 2015/16 Commissioning for Quality Improvement Payment Framework (CQUIN) and as part of one acute provider’s Quality Accounts priorities for 2015/16.
### Table 19: National quality schemes 2015/16

<table>
<thead>
<tr>
<th>Theme</th>
<th>Plan</th>
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| **Sepsis and Acute Kidney Injury** | Participate in the development of Commissioned Services (Acute) Quality Account priorities for 2015/16  
|                              | Review National quality incentives (which include sepsis and acute kidney injury) quarterly CQUIN reports from Commissioned Services and take decision on payment.                                                                                                                                   |
|                              | Perform a deep dive of quality improvement programmes (e.g. the Enhancing Quality Programme) that focus on these topics and discuss periodically at the Clinical Quality Review Meeting                                                                                                                                          |
|                              | Continue to attend the acute commissioned service mortality review meetings and ensure thorough scrutiny of the results of mortality audits and avoidable causes of death                                                                                                                                 |
|                              | Participate in the Patient Safety Collaborative Work Programmes that focus on acute kidney injury and sepsis                                                                                                                                                                                                             |
|                              | Ensure the NHS Contract with acute service include a focus on acute kidney injury and sepsis                                                                                                                                                                                                                                  |

#### 6.19 Improving Antibiotic Prescribing

There is the recognition that antimicrobial resistance (AMR) and antibiotic prescribing are inextricably linked and in turn AMR is a major threat to patient safety – particularly as it increases patient’s risks of having serious infections such as *Clostridium difficile* and *Methicillin-Resistant Staphylococcus Aureus*.

The G&WCCG Medicines Management Team (MMT) lead at local level with neighbouring CCGs on the adaptation and agreement of the primary care management of infection prescribing guidance - which is based on the Public Health England (PHE) template. The latest update was agreed in December 2014 (for review October 2017) by the Prescribing Clinical Network (PCN) and is available on the PAD (Prescribing Advisory Database).

There are plans underway to continually improve antibiotic prescribing, and for 2015/16 they are as follows:

- Practices will be requested to support European Antibiotic Awareness Day (EAAD) November 18th 2015 as part of the LPS  
- EAAD will also be promoted locally to community pharmacies and other provider services in the local area, linking again with neighbouring CCGs.  
- Prescribing monitoring data will be produced and disseminated to GP practices on a quarterly basis for the following indicators:  
  - Items/STAR-PU (prescribing volume measure)  
  - % High risk antibacterials (to included quinolones, cephalosporins and co-amoxiclav)  
- Take the necessary action to ensure achievement of the antimicrobial aspect of the Quality Premium including consideration of incentivizing the acute provider
• Antibiotics to be a focus for the ‘local prescribing scheme’ (LPS) which supports Quality Improvement Performance Plans in General Practices
• Audit prescribing or focus on a specific piece of work such as the use of patient information leaflets (PIL) i.e. ‘Treating your infection’ (the PIL and a variety of documents are available via the TARGET toolkit).
• Continue to engage with the local acute Commissioned Service Antibiotic Steering Group and support initiatives as required

6.20 Patient Experience and Engagement

Improving patients’ experience of health care is a key driver in our commissioning relationship with our providers. Although the Friends and Family Test will not feature in the 2015/16 CQUIN, patient experience will be included as a standing item at the Clinical Quality Review Meeting every quarter, with the RSCH (our major provider) expected to present their reports for assurance purposes. We will continue to attend the monthly Friends and Family Test Steering Group held by the RSCH and through this scrutinise poor experience and work with the RSCH on improvement plans.

Planned clinical visits are scheduled throughout 2015/16 to capture patient experience of services and we will, in particular, focus on mental health settings including frail elderly dementia, reflecting our ageing population’s health needs.

We will attend Care Quality Commission Listening Events as and when these are held.

We have encouraged Patient Participation Group Chairs (through our network meetings) to join the RSCH’s quality accounts meetings to scrutinise and ensure they are achieving their quality objectives and bring patient experience that they are aware of to these meetings.

In 2014/15 we developed a software tool for GP practices to use to deliver the Friends and Family test in primary care, a tool with a range of feedback mechanisms (manual, online and SMS) that also asks for limited demographic information. The aim was to help practices to improve patient experience through use of a robust FFT tool that took equality considerations into account. In 2015/16, the FFT software will be further developed to request additional demographic information to ensure that the experience of patients in more equality groups can be identified and improved.

Complaints will continue to be regularly reviewed with quarterly reports to the Quality & Clinical Governance Committee providing oversight and a place to review themes to inform actions to improve patient experience. The CCG will improve its website in quarter 1 of 2015/16 to address findings from Healthwatch Surrey’s review of complaints mechanisms meeting the needs of those who wish to complain.

Good engagement with patients and the public, listening to what they say and truly reflecting their feedback is one of the six assurance domains that the CCG continues to develop and improve. The Communications and Engagement
Strategy is a two-year programme of action (2014-16) that will result in regular, diverse input from patients and the public to our commissioning plans and implementation. This details the wide variety of actions that will be implemented throughout 2015/16. Our aim is to provide substantial assurance that our Patient & Public Engagement is effective, accessible and transparent.

We will continue to increase the diversity of our Patient & Public Engagement Group to reflect the community we commission for, as described in section 4.1. This group will continue to be involved with developing engagement plans related to our commissioning intentions. Overall, we will carry out wider engagement with the public on all aspects of the Operational Plan, including the integrated care partnership model. We will ensure we have conversations with our varied patient and public community regarding the financial challenges faced by the CCG and involve them in decision making.

We will utilise the framework provided by the Equality Delivery System to engage with our population on specific health care services, as described in Section 4.3 above.

6.21 Compassion in Practice

The ‘NHS Nursing Strategy: Compassion in Practice’ sets out a shared purpose for nurses, midwives and care staff to deliver compassionate, high quality care, achieving excellent mental and physical health and wellbeing outcomes. The strategy centres on core values and behaviours that have equal application for all health professionals. These are encapsulated by the 6Cs (care, compassion, competence, communication, courage and commitment) and expressed by G&WCCG as:

- **Care** - Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

- **Compassion** - Compassion is how care is given through relationships based on empathy, respect and dignity; it can also be described as intelligent kindness and is central to how people perceive their care.

- **Competence** - Competence means all those in caring roles must have the ability to understand an individual’s health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

- **Communication** - Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for staff and patients alike.

- **Courage** - Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.

- **Commitment** - A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to
improve the care and experience of our patients to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

Since the launch of Compassion in Practice there have been several other publications that have re-inforced the principles and actions outlined in the strategy such as Hard Truths, the Berwick Report and the Keogh review.

These build on the enduring values of the NHS and the rights and pledges of the NHS Constitution. The actions set out in the strategy are:

- Staying independent, maximising wellbeing and improving outcomes
- Improving patient experience
- Delivering high quality care and measuring impact
- Building and strengthening leadership
- Right staff, right skills, right place
- Supporting positive staff experience

The delivery of Compassion in Practice actions are embedded into the quality review process with providers. These are integral to delivery of the planned Service Transformation in 2015/16, demonstrated through:

- Provider plans delivered against the six action areas of the Compassion in Practice agenda and monitored through the monthly Clinical Quality Review Meetings.
- Clinical site visits with providers, as part of the workplan of the Quality and Clinical Governance Committee (with participation from lay members, GPs, clinical staff).
- Integrated working across the whole health and social care economy to deliver improved outcomes for the frail elderly and those with dementia. The newly established multi-disciplinary teams will promote independence, wellbeing and the positive outcomes for individuals, in line with the dignity and respect agenda.
- Terms of reference for the multi-disciplinary teams in the localities to include reference to the 6Cs as a core objective of the meetings.
- Inclusion of the 6Cs in the frailty initiative specification and in the job description of the locality case co-ordinators.
- Public experiences of care influencing changes to care and service delivery, with genuine engagement in service redesign through the weekly Hospital Implementation Group and sub-groups.
- Celebration and sharing of the implementation of the 6Cs at the 2015/16 Annual Conference, attended by health and social care professionals, patients and carers.
- Transparency about quality of care through metrics presented in reports at Governing Body and at the Quality and Clinical Governance Committee.
- Focused development of an integrated workforce, ensuring that staff roles, skills and competencies reflect the future local service delivery requirements across all professional groups, through links with Health Education England Kent, Surrey and Sussex (HEEKSS).
- In collaboration with HEEKSS and Surrey University, hosting a Primary Care Workforce Tutor, with clear objectives to improve the recruitment,
retention and succession planning in primary care, with a specific focus on Practice Nursing and General Practitioners.

- Assurance of leadership development opportunities within commissioned providers and through success rates in ‘Achieving Excellence’ targets, aimed at supporting multi-disciplinary teams and individuals to understand their role in making continuous improvement part of their everyday work.

6.22 Staff Satisfaction

Staff satisfaction in Commissioned Services is referenced in the quality section of this Plan, and specifically the plans relating to assessing and reviewing robust quality assurance around workforce statistics. This will include national and local staff survey results from commissioned services. Action plans will be sought for sub-optimal areas, and regularly monitored at providers’ clinical quality review meetings.

The NHS Constitution outlined the principles and values of the NHS in England including four pledges that set out what staff should expect from NHS employers. The more positive the experiences of staff within an NHS organisation, the more engaged staff members are, the better the outcomes for patients and the organisation generally.

Measures of improved staff satisfaction will be supported in 2015/16 through:

- Implementation of HR/OD strategies;
- NHS Staff Survey results;
- Responsive, relevant communication through Team Briefs, E-brief and the intranet portal;
- Publishing opportunities for promotion;
- Leadership Skill development through KSS Leadership Academy;
- HR policies;
- Completion of robust Appraisals and Personal Development Plans
- Implementation of Exit Interviews, conducted by HR, reported to CO with lessons learned used to improve employee experience;
- Locally agreed benefits including eye care vouchers, Occupational Health and Employee Assistance Programme;
- Staff Partnership Forum to promote employee relations;
- Guildford Organisation Learning and Development (GOLD) Awards are presented to staff nominated by peers for their achievements within the following categories;

  a) Exceptional contribution to Quality Innovation and transformation
  b) Outstanding contribution to the work of the CCG
  c) Team of the year
  d) Collaborative Working
  e) Lifetime achievement
  f) Chairman’s Award
The CCG has a number of Health and Wellbeing initiatives including:

a) a Staff Bicycle scheme  
b) discounted gym memberships and discounted health memberships  
c) Occupational Health Service, including an Employee Assistance Programme  
d) HR policies supporting staff wellbeing in accordance with the NICE guidance relating to No Smoking, Drug and Alcohol abuse, Dignity at Work and other HR related policies.  
e) Promotion of National Awareness Schemes, such as ‘Time to Talk’ Day  
f) Working with our Staff Partnership Forum, to measure work-related stress through our annual Staff Survey

The outcomes will be measured through:

- Improved retention of staff;  
- Lower levels of sickness absence;  
- Internal promotions and development;  
- Good response rate and improved Staff Survey results.

6.23 Workforce Race Equality Standard

G&WCCG is committed to the implementation of the required Workforce Race Equality Standard (WRES) from 1st April 2015.

We will adhere to any further developmental work on the applicability of the WRES to CCGs. The CCG will prioritise:

- A higher level of awareness of the purpose of, and work needed for, the WRES within the CCG  
- A commitment that every effort will be made to ensure that levels of returns on ethnic monitoring within the CCG is sufficiently high to provide assurance on data analysis  
- To engage Black and Minority Ethnic staff (BME) and all staff generally with these priorities  
- A commitment to collating the required data for April 2015, as indicated within the NHS England ‘Technical Guidance for the NHS Workforce Race Equality Standard (WRES)’ for publication by July 1st 2015, as stipulated by the WRES Technical Guidance Group.

In 2015-16, the CCG will:

- Use the nine indicators contained in the WRES to help improve workplace experiences, and representation at all levels within our workforce, for Black and Minority Ethnic Staff (BME).  
- Compare our Staff Survey results with the CCG’s previous survey results; and benchmark our results with those of other neighbouring CCGs
• Review any specific issues relating to specific professional groups or departments
• Review our understanding of the root causes behind any differences between BME and White staff treatment and experience identified for each of the indicators and suggest ways to improvement
• Provide assurance that our Providers are subject to the NHS Standard Contract, (exception of ‘small providers’ whose aggregate annual income for the Contract Year does not or is not expected to exceed £200,000) and will be expected to collect, analyse and publish relevant workforce data in respect of their staff providing NHS service, as commissioned by the CCG.

6.24 Seven Day Services

The underlying principle as to how we change services is to provide more care in community and primary care settings, to free up the demand on acute hospitals to enable them to focus on those services they are best placed to deliver. Key to this is to reduce the demand for emergency care by increasing access to primary care, and for primary care and community services to work together to support those with long term conditions, or at risk of developing them, to manage their conditions and avoid the need for hospital care.

It is the responsibility of NHS England (through national GP contract) and CCGs to develop and implement plans to secure Wider Primary Care, at Scale. This includes the expectation that GP practices will be commissioned to offer extended opening hours and support the delivery of Sir Bruce Keogh expectation that NHS move towards providing access to all services 7 days a week.

Primary Care commissioning meetings will be held on a quarterly basis to provide the forum to be more involved with the Kent, Surrey and Sussex Area Team through 2015/16. The CCG will undertake a feasibility study during 2015/16 to identify what the quantifiable benefits would be for all stakeholders, including patients, whilst maintaining financial and provider sustainability.

RSCH is working on a number of initiatives to increase its 7 day working presence. These include developing plans for providing greater access to diagnostics and therapies. In terms of consultant presence and review and assessment of seriously ill patients the Trust achieves this in a number of areas currently. The Trust plans through its proposed merger with ASPH that it will deliver 7 day working in a number of areas more quickly and sustainably. Detailed work has begun in three clinical areas; Gastroenterology, Interventional Radiology and Stroke. Throughout 2015/16 the Trust will continue to develop proposals for extending 7 day working across the Trust working in line with the national timetable.

6.25 Safeguarding

6.25.1 Adults

G&WCCG is a key stakeholder on the Surrey Safeguarding Adults Board (SSAB) and is committed to working with all relevant partner agencies. G&WCCG has a
dedicated Designated Nurse for Safeguarding Adults, in addition to the Surrey-wide Designated Nurse collaborative arrangements. The G&WCCG Designated Nurse has a clear remit to ensure that contracting arrangements with its providers focus on the safeguarding and quality agenda. The plans for 2015/16 are as follows:

- Continue to contribute to the Safer Waverley Partnership Action Plan 2014-17
- Implement actions at a local CCG level, in line with SSAB objectives for 2015/16
- Promote a safeguarding culture and embed closer partnership working with carer organisations within G&W
- Develop a robust Safeguarding Adults Dashboard to closely monitor safeguarding and quality concerns in care homes within Guildford & Waverley
- Continue to work in partnership with the Quality Assurance Team at Surrey County Council to monitor quality and safeguarding themes within care homes and other independent providers
- Continue to hold bi-monthly Quality meetings in collaboration with the CQC and Local Authority to share intelligence about local care providers
- Embed the safeguarding agenda in the quality assurance processes with providers commissioned by G&WCCG

During 2015/16 G&WCCG will develop and support the ambition for the safer delivery of services through the integrated team developments at locality level, with a particular focus on the prevention of safeguarding incidents and the empowerment of local people through the personalisation, choice and control agenda.

In response to the Care Act 2014 and the new statutory responsibilities of Safeguarding Adults Boards, a Health Sub-Group will be established, with meetings held on a quarterly basis. G&WCCG will represented at these meetings by the Executive Nurse/Director of Quality and Safeguarding and there is a plan to overlap a section of the Safeguarding Children’s Health sub-group with the Adults group, in recognition of the joint agenda with Serious Case Reviews, Domestic Abuse, Prevent, Domestic Homicide Inquiries and Signs of Safety.

At a local level, collaboration will continue between the CCG's Designated Adults and Children's Nurses and GP Clinical Leads, with regular Safeguarding sub-group meetings, held under the auspices of the Quality and Clinical Governance Committee. This enables greater opportunities for sharing information and delivery of the key safeguarding objectives between commissioners, primary care and key stakeholders.

The safeguarding sub-group will provide the mechanism to assure the CCG’s Governing Body that lessons emerging from the introduction of the Care Act, Safeguarding Adult Reviews and Domestic Homicide Reviews are shared, with the robust oversight to monitor the delivery of actions. A monthly safeguarding adults and children exceptions report is presented to the Quality and Clinical Governance Committee.
It’s anticipated that through the implementation of the plans above greater opportunities will exist to share the learning amongst the wider health and social care economy throughout Guildford & Waverley. For example the Safeguarding Adults Dashboard closely monitoring care home activity will provide an opportunity to tailor required resources within those homes where quality or safeguarding concerns have been highlighted.

6.25.2 Children

G&WCCG leads on safeguarding children across the county and is a key partner on the Surrey Safeguarding Children Board (SSCB). As an active member on this board the CCG is committed to working with all relevant partner agencies.

G&WCCG hosts the Surrey-wide Safeguarding team that is fully compliant with legislative requirements.

The CCG’s ambition and over-riding objective is to ensure there is continuous learning and improvement in the practice of safeguarding children. This will be achieved through the CCG’s oversight of this area of practice across the health economy and by ensuring the lessons from national and local case reviews, reports such as the Savile enquiry and inspections, are communicated and embedded into practice. This ambition is reflected in the plans for 2015/2016 which will ensure that the CCG both as a commissioner and employer is able to evidence compliance with Section 11 of the Children Act 2004 and develops services that reflect best practice that are responsive to both national and local learning. In order that this may be achieved the CCG will:

- Maintain oversight of the health economy-wide action plan developed in response to the recent CQC inspection recommendations.
- Provide strategic health representation at multiagency boards that are shaping new initiatives, including the on-going development of the MASH and implementation of the Signs of Safety
- Provide strategic leadership in ensuring the priorities of the safeguarding children board, Child Sexual Exploitation, Domestic Abuse and Early Help, are evidenced within all health providers safeguarding practice.
- Ensure G&WCCG and the services they commission can demonstrate compliance with statutory guidance including “working Together to safeguard children” 2013. The Section 11 process will provide such assurance.
- Ensure, through the implementation of the safeguarding children dashboard and accountability and assurance framework developed by the county wide safeguarding children team that G&WCCG’s contractual arrangements with provider organisations are quality assured around safeguarding children. The dashboard is a dynamic document that is reviewed and updated to meet both local and national priorities.
- Ensure G&WCCG continue to meet their statutory duty to be members of Local safeguarding children’s boards, working in partnership to fulfil their safeguarding responsibilities.
• Ensure G&WCCG and providers they commission services from have robust processes in place to learn from serious safeguarding incidents and promote such learning across the county to ensure a robust safeguarding system
• Ensure there are effective NHS safeguarding arrangements across G&WCCG health economy. This will be evidenced through the dashboard and health economy wide safeguarding children audit.
• Demonstrate that the Designated safeguarding team, as clinical experts, are fully consulted in the clinical decision making of the organisation
• Ensure G&WCCG is managing and monitoring risk associated with safeguarding children within the G&WCCG area.
• Ensure G&WCCG Staff are appropriately trained to safeguard and promote the welfare of children.

6.25.3 PREVENT

PREVENT is part of the Government’s strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. CONTEST focuses on all forms of terrorism. As such, PREVENT forms part of the overall safeguarding agenda. The aim of PREVENT is to ensure that there are preventative strategies in place across all agencies to support and divert people who may be susceptible to radicalisation, before they become directly involved in any illegal activity relating to acts of violence or terrorism. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial.

Over recent months the situation in Syria and the Middle East has highlighted the issue of violent extremism and how certain individuals are susceptible to radicalisation; the recent attacks in Paris and Copenhagen have demonstrated how difficult it can be to recognise and report individuals who are at risk or have been radicalised. Issues around radicalisation within the United Kingdom have also received considerable media attention over the past few years with examples including the murder of Fusilier Lee Rigby and the radicalisation of young people attracted to join jihadi groups in the Middle East and North Africa. In response NHS England has developed a PREVENT training and competencies framework. The purpose of this document is to encourage a consistent approach to raising awareness of PREVENT strategy, which is a part of the wider safeguarding agenda. It has been developed to support NHS providers (including providers of NHS services commissioned in the private and 3rd sector) in meeting their contractual obligations in relation to the PREVENT strategy. It is the role of the Clinical Commissioning Group to hold the providers to account on the NHS Standard Contract requirements.

There are a number of plans for PREVENT in 2015-16:

• G&WCCG via NHS England are awaiting confirmation from the Home Office regarding the funding of Regional Prevent Co-ordinators in 15/16.
• G&WCCG is ensuring providers are meeting in full their responsibilities for the *Prevent* agenda as outlined in the standard NHS contract.
• The expectations outlined in the Prevent agenda will be monitored at the commissioned providers Clinical Quality Review Meeting to ensure that all expected requirements are being met as laid out in the Accountability and Assurance Framework document.

6.26 Mental Capacity Act

G&WCCG is committed to supporting quality improvement in the application of the Mental Capacity Act. NHS Surrey Downs CCG is the lead commissioner for the Mental Capacity Act in Surrey, and G&WCCG will work closely with them to ensure that the duties are met within the services they commission. The plans for 2015/16 are as follows:

• G&WCCG to work with NHS England to update existing Mental Capacity Act prompt cards
• The expectations outlined in the Mental Capacity Act will be monitored at the commissioned providers Clinical Quality Review Meeting to ensure that all expected requirements are being met as laid out in the Accountability and Assurance Framework document
7.0 INNOVATION

7.1 Research and Innovation

In addition to adopting the principles and philosophy of the Department of Health’s ‘Innovation, Health and Wealth: accelerating adoption and diffusion in the NHS’ the CCG also has a statutory obligation to promote and support research to improve the quality of healthcare services in the future. To this end we will ensure that where required, research is facilitated, performed or encouraged through appropriate stakeholders, and in accordance with best practice research governance principles. We will do this in a number of ways:

- The Surrey Transformation Board, which is chaired by our CCG Chair, will include representatives from the Academic Health Science Network (AHSN). Their remit will be to review transformation across Surrey using research and innovation, and will provide the essential link to the work streams led by that organisation;
- As part of Surrey Clinical Commissioning Groups Collaborative we will continue to bid for various research monies. We will also continue to be part of a bid to the Strategic Clinical Network (Senate Programme Budget 2013-14) to support a transformational programme around Stroke and cardiovascular diseases in Surrey. This bid is designed to help create a healthcare environment that will be fit for purpose with Keogh’s vision for Transforming Urgent and Emergency Services;
- Through the Surrey CCGs Collaborative, we continue and will expand our links to Research Networks focusing on an array of various topics. This will include; Cancer; Cardiovascular; Maternity and Children; Mental Health, Dementia and neurological conditions;
- Progress to research projects and the research programme will form part of the Quality and Governance Committee’s regular work plan – which will be discussed on a quarterly basis at the Committee meeting. The discussion will incorporate and triangulate any risks or issues concerning quality to ensure that future topics focus on the improvement of healthcare services;
- As part of the Surrey CCGs Collaborative, we will continue to be represented on the Clinical Senate.
- The newly formed Primary Care Clinical Academic Group exists as a partnership initiative to promote and facilitate research in the primary health care setting which can impact on the quality, safety and effectiveness of health care and patient experience.
- The membership and Terms of Reference of the currently existing G&WCCG Clinical Research Forum are incorporated into the new Clinical Academic Group (CAG).
- Membership is broadened through inviting those interested in research in member practices and representatives of Governing bodies of the Surrey CCG’s and representatives of Surrey Health Partners to participate.
• Progress of the CAG is reported to and monitored by the Quality and Governance Committees of the CCGs who elect to be involved.
• The CAG is jointly led by a University of Surrey senior staff member and a G&WCCG Governing Body member (G&WCCG is the founding CCG).
• Research themes, quality improvement projects, and promoting education will be decided and prioritised by the CAG.

7.2 The CCG are currently working on a range of initiatives. The evolution of AHSNs in the NHS takes place in the context of three significant issues:

• the challenge to the UK of economic recovery and sustainable growth especially within the life sciences industries.
• organisational development within the NHS including clinically-led commissioning
• the ageing population and associated challenges to rising health care costs

7.3 G&WCCG are working with Kent, Surrey and Sussex AHSN to undertake a Dementia Harmonisation programme, implementation of the research project - PACE care planning in Primary Care.

7.4 The CCG commission’s high quality services and works towards achieving NICE compliance, regular reports are presented to the Quality and Governance Committee setting out areas of strength and where improvement can be made. This is all made against a backdrop of financial efficiencies and all service transformation projects have a quality impact assessment completed to ensure that proposals are not detrimental to service provider and patient outcomes.

7.5 Performance and activity data is available to CCG staff and the practice members through SharePoint. This allows the GPs to review the activity levels for their patient population and identify solutions that effectively maintain the planned trajectory of activity. Work with the University of Surrey and Kent, Surrey and Sussex to analyse the segmentation of the population will inform the demand and capacity plans that will be required to effectively redesign the health and social care community services.

7.6 The CCG are currently piloting a health coaching scheme which has been shown to reduce unplanned admissions and improve patients’ ability to self care. The pilot is working with COPD patients over a six month period to provide proactive individualised health coaching. The Guildford and Waverley Health Coaching Scheme is provided by Totally Health who have a long term, sustainable model of care by providing highly trained clinical health coaches to motivate and educate patients about their condition and lifestyle. Their aim is to empower patients to self-care in the community thereby resulting in a better quality of life for patients, reduction in inappropriate A&E attendances and savings for the health economy.
7.7 In August of 2014 the CCG launched an Advice & Guidance Line provided by the Cardiologists at the Royal Surrey County Hospital and GpCare (a GP federation in Bristol). The line utilises cutting edge technology which on termination of the call automatically saves the entire conversation as a WAV file in the patient specific notes within the GP Practice. This enables GP’s to access a Consultant for queries relating to any aspect care for patients with cardiological conditions. Consultants are placed on a rota which ensures any calls goes through a hunt group and is answered by the first available clinician. The aim of the line is to integrate primary and secondary care and reduce unnecessary referrals.

7.8 In 2013 the Telehealth programme was commissioned to support patients with long term health conditions. It enables individuals to take more control over their health, and becomes an intrinsic part of their care pathway with specialist nurses monitoring the submitted results. It works by providing patients with pods which monitor vital signs and ask key health questions. Data is electronically transmitted directly to a Telehealth nurse where it is monitored against parameters set by the clinician. Telehealth nurses will take appropriate action in line with the personalised care plan, ensuring vulnerable patients are monitored closely and swift action is taken when any deterioration is apparent.

7.9 In order to support the ‘Integrated Care Partnership’ scheme, and with the overall aim of supporting patients to remain at home with the necessary support, G&WCCG are intending to fund an innovative software system called ‘Rally Round’. This electronic package enables a carer, friend, or AGE UK coordinator to generate task lists specific to an individual who requires assistance with day to day tasks and shares it with volunteers who have agreed to ‘Rally Round’ that person. Volunteers (friends, family, neighbours, AGE UK staff) are invited to view the patient specific page and tick which task they can undertake and when. They are then provided with electronic reminders to ensure the task is carried out. Tasks such as ‘Changing a light bulb’, ‘doing the shopping’, mowing the lawn’ are all undertaken in an organised and documented way ensuring that one person does not hold all the responsibility. Tasks are ticked and removed when they are completed. This software has worked well when commissioned by County Councils in other areas but this will be the first time it will be commissioned by a CCG.

7.10 In order to ensure that available technology is trialled and implemented to support patients and health care teams, G&WCCG are exploring the possibility of commissioning a mobile phone app, which is being used in mental health services in other CCG areas, called ‘buddy’. This is a texting system which the patient’s consultant queues in order to remind and suggest activities for a patient at set intervals. An example would be “How about a walk today” or “have you remembered to take your medication”. It can also be set to ask the patient about moods and symptoms which the patient can reply to with a score. The consultant
can then access the replies to analyse trends and behaviour patterns. This app does not require a smart phone and has been shown to help the patient feel they are still being cared for in between appointments with their team.

7.11 After identifying that the pathway for patients with suspected DVT was fragmented for both patients and medical staff within secondary care, the CCG have commissioned a scheme whereby GP’s can assess and treat patients for DVT within their Practices. This has been made possible by the use of new oral anticoagulants which are not currently in general use within General Practice. This will ensure patients get quicker treatment and do not need multiple visits to secondary care, possibly enduring long waits in A&E.
8.0 DELIVERING VALUE

8.1 Our vision is underpinned by financial sustainability. If we can deliver that vision of fully integrated health and social care services, we will deliver a high quality, sustainable NHS in future years. To achieve this we need to shift resources from the acute sector to the primary care sector.

8.2 The QIPP programme was set up by the Department of Health to improve care and lower costs in the NHS. Our intended Service Transformation savings of 6.3%, in addition to provider efficiencies over the next year, will create a sustainable NHS in line with the ‘Call to Action’.

8.3 Our strategic direction of travel and many of our operational initiatives will have significant implications for our providers. To succeed we will need to work through, understand and sensitively manage these challenges.

8.4 G&WCCG was required to deliver a surplus of £2.9m in 2014/15, which we achieved (£3.0m), but this required considerable financial support. The CCG has an underlying recurrent deficit and faces a significant financial challenge in 2015/16. The net QIPP target is £15.2m which must be addressed through the Service Transformation Programme.

Table 20 QIPP Delivery

<table>
<thead>
<tr>
<th>Area</th>
<th>Headline scheme</th>
<th>QIPP 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Care</td>
<td>Integrated Care Partnership</td>
<td>3,160</td>
</tr>
<tr>
<td></td>
<td>- Frailty initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Age UK</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- IBIS care plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent Care Project</td>
<td>1,801</td>
</tr>
<tr>
<td></td>
<td>- Winter Campaign</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- SOS bus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A&amp;E Pathway</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Single Discharge project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planned care reductions</td>
<td>6,225</td>
</tr>
<tr>
<td></td>
<td>- RSS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pathway redesign including</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cardiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Gynaecology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ophthalmology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other Service Changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DVT / Anticoagulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicines Management</td>
<td>2,000</td>
</tr>
<tr>
<td></td>
<td>- Rebates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Care home Project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patent expiry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cost reductions as per Astro</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other acute contract review and contract challenges</td>
<td>715</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaborative cost review including CHC Management</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>CHC placement costs</td>
<td>1,050</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>15,185</td>
</tr>
</tbody>
</table>
8.5 The draft financial plan for 2015/16 shows that the CCG is planning to deliver a breakeven position, which does not meet the national business rules of delivering a 1% planned surplus. In addition, the CCG is planning to fund a 1% non-recurrent strategic investment reserve and a 0.5% contingency reserve, in accordance with the planning requirements, and the repayment of the financial support to Surrey CCG’s in 2015/16.

Table 21 Application of funds 2015/16

<table>
<thead>
<tr>
<th>Description</th>
<th>Total budget for 2015/16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commissioning Services</strong></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>128,849</td>
</tr>
<tr>
<td>Mental health</td>
<td>22,659</td>
</tr>
<tr>
<td>Community</td>
<td>23,245</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>15,951</td>
</tr>
<tr>
<td>Primary Care</td>
<td>32,471</td>
</tr>
<tr>
<td>Other Programme services</td>
<td>6,660</td>
</tr>
<tr>
<td><strong>Sub Total - Commissioning Services</strong></td>
<td>229,835</td>
</tr>
<tr>
<td>Other Corporate costs (Non Running costs)</td>
<td>2,369</td>
</tr>
<tr>
<td><strong>Sub Total - Other Corporate costs</strong></td>
<td>2,369</td>
</tr>
<tr>
<td>Running costs</td>
<td>4,564</td>
</tr>
<tr>
<td><strong>Sub Total - Running costs</strong></td>
<td>4,564</td>
</tr>
<tr>
<td>Planning requirements and reserves</td>
<td></td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>1,206</td>
</tr>
<tr>
<td>General Reserves</td>
<td>3,978</td>
</tr>
<tr>
<td><strong>Sub Total - Reserves / support</strong></td>
<td>5,184</td>
</tr>
<tr>
<td><strong>Total application of funds</strong></td>
<td>241,952</td>
</tr>
<tr>
<td><strong>Resource Limit</strong></td>
<td>241,952</td>
</tr>
<tr>
<td><strong>Surplus / Deficit</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

8.6 The 2015/16 CCG allocation baseline is £242m, including the running cost allowance of £4.8m, the BCF allocation of £3.3m and the £1.226m allocation for operational resilience funding. This represents an uplift of 2.09% for growth, equating to £4.7m. The % changes adopted for growth and efficiency are summarised in table 22 below, with the impact in terms of key bridging movements detailed in table 23:
Table 22 Growth and efficiency

<table>
<thead>
<tr>
<th></th>
<th>Growth</th>
<th>Efficiency</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>1.90%</td>
<td>-3.50%</td>
<td>-1.60%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2.09%</td>
<td>0.00%</td>
<td>2.09%</td>
</tr>
<tr>
<td>Community</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2.50%</td>
<td>0.00%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>2.50%</td>
<td>0.00%</td>
<td>2.50%</td>
</tr>
</tbody>
</table>

Table 23 Key bridging movements

8.7 The running cost allowance is net of the required 10% reduction in 2015/16.

8.8 The CCG is planning for a transfer of funding to the BCF in 2015/16 of £11.6m.

8.9 The CCG investment reserves are committed to deliver known developments, investment required for any new schemes will need to cover project implementation costs before net savings are generated.
## GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHSN</td>
<td>Academic Health Science Network</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Services</td>
</tr>
<tr>
<td>EDS</td>
<td>Equality Delivery System</td>
</tr>
<tr>
<td>ENP</td>
<td>Emergency Nurse Practitioners</td>
</tr>
<tr>
<td>G&amp;WCCG</td>
<td>Guildford &amp; Waverley Clinical Commissioning Group</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Programme</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality Innovation Productivity &amp; Prevention</td>
</tr>
<tr>
<td>QSG</td>
<td>Quality Surveillance Group</td>
</tr>
<tr>
<td>RAT</td>
<td>Rapid Assessment and Treatment</td>
</tr>
<tr>
<td>RSCH</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>SLT</td>
<td>Speech &amp; Language Therapy</td>
</tr>
<tr>
<td>SRG</td>
<td>Systems Resilience Group</td>
</tr>
</tbody>
</table>