NHS Guildford and Waverley Operational Plan 2016/2017
## CONTENTS

1. **Executive Summary** .......................................................... 4

2. **Promoting, protecting and improving the health wellbeing of our local population** .......................................................... 9

3. **Sustainability and Transformation Plan** .................................. 21

4. **Achieving financial balance** .................................................. 25

5. **Sustainability and quality of general practice** ............................ 46

6. **Reducing demand on emergency services** ............................... 54

7. **NHS Constitution standards** .................................................. 64

8. **Cancer services** .................................................................. 65

9. **Mental Health Services** .......................................................... 75

10. **Transforming care for people with learning disabilities** ............ 82

11. **Research and Innovation** ....................................................... 85

12. **Improvements in Quality** ..................................................... 88
Figure Index
1. Rightcare improving value and outcomes summary
2. Plan on a Page
3. Surrey Heartlands STP Footprint map
4. Key bridging movements
5. Rightcare process flow
6. Rightcare spend and outcomes
7. Achieving world class cancer outcomes
8. Surrey Learning Disability Partnership Vision

Chart Index
1. Projected growth of the over sixty-five population in Guildford and Waverley CCG compared with England
2. Projected growth of the over eighty-five population in Guildford and Waverley CCG compared with England
3. STP Governance framework
4. Incomplete pathways Royal Surrey County Hospital (for all) – snapshot March 2016
5. Breach analysis for (All) incomplete pathways at Royal Surrey County Hospital

Table Index
1 Commissioning Intentions Target dates
2 2016/17 QIPP Schemes
3 Application of funds 2016/17
4 Growth and efficiency
5 Parity of Esteem investment schedule
6 Improving Value Schemes
7 Unplanned Care programme projects
8 A&E Recovery Plan
9 Unplanned Care Programme Critical Milestones and deadlines
10 Snap shot position of in completes and will change on a daily basis
11 Cancer Improvement Critical Milestones and deadlines
12 Improving IAPT critical milestones and deadlines
13 Mental Health critical milestones and deadlines
14 Dementia improvement critical milestones and deadlines
15 Learning Disabilities improvement critical milestones and deadlines
16 Learning Disabilities Transformation Care critical milestones and deadlines
17 Freedom to speak up critical milestones and deadlines
18 Quality Strategy 2016/17 critical milestones and deadlines
1. Executive Summary

1.1 This Operational Plan represents year 1 of our 5 year strategy and highlights the key programmes of work we have planned for 2016/17, together with the outcomes we expect to achieve.

1.2 The healthcare system is facing the challenge of significant and enduring financial pressures. People’s need for services continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

1.3 Identifying these challenges and clearly setting out the actions required will ensure that the CCG achieves a position of recurrent financial balance whilst improving the quality of patient care and improving patient outcomes.

1.4 Guildford and Waverley CCG is proud of the significant benefits it has already delivered for its local population, with oversight from the Governing Body, close working with its 21 Member Practices and in collaboration with key stakeholders and patient reference groups. The feedback we receive through patient and public engagement is highly valued by the CCG as it informs improved service delivery, with patient and carer experience at the fore, as well as providing opportunities for learning and emulating best practice from the wider health service. We would like to thank our Patient and Public Stakeholder Group for their continuing commitment in this regard. These are some of the achievements we have delivered:

- Supporting the system to reduce A&E attendances within our local acute provider (Royal Surrey County Hospital NHS Trust (RSCH)) through:
  - Whole system focus on pathways of care through the System Resilience Group and the Better Care Fund Local Joint Commissioning Group;
  - Commissioning the Primary Care based Frailty Initiative that supports frail older people in their local community and high quality proactive anticipatory care planning that is used by the emergency services; this has significantly reduced unnecessary ambulance conveyances;
- Improving discharge pathways and significantly reducing excess bed days.

- Supporting patients who are reaching the end of their life to be cared for and to die in their chosen setting, by developing an integrated specialist palliative care service provided by the local hospice;

- Improving care for patients in care homes by commissioning targeted support to community care homes, focusing on medication reviews, end of life care planning and treating, where appropriate, patients outside of acute care settings;

- Reducing length of stay by commissioning an integrated discharge team, a discharge to assess model and access to packages of care in the community;

- Achieving a reduction in elective activity, compared to 2014/15, supporting practices to improve the quality of referrals, implement alternative triage pathways, such as, Musculoskeletal, Community Gynaecology Service and Deep Vein Thrombosis pathway.

1.3 We have strengthened commissioning skills and expertise, quality and governance mechanisms and processes for working in collaboration with our neighbouring CCG colleagues. This is particularly important for Surrey wide commissioning and decision making, for example stroke, children community health services, child and adolescent mental health services.

1.4 We will plan for the local population across an extended footprint which will include, in addition to Guildford and Waverley, Surrey Downs and North West Surrey. In collaboration with Surrey County Council, we will develop a shared vision to improve delivery models and achieve efficiencies for the health and care sector whilst safeguarding quality. The Better Care Investment Plan for 2016/17 will continue to support the commissioning of integrated care.

1.5 During 2016/17, we have made significant progress developing Surrey Heartlands Sustainability and Transformation (STP) Plan. We have established six condition specific key work streams and a number of cross cutting work streams that will support the progress towards our collective large scale transformation programme required to reduce the gaps in health and wellbeing, care and quality, and finance and efficiency.

1.6 It is recognised, across the local health and care economy, that there needs to be a significant shift in resources from the hospital setting into community
and primary care. We will commission proactive and responsive community services that reduce reliance on beds and enable the acute sector to focus on providing the specialist assessment, treatment and care for patients who are acutely unwell. Patients with long term chronic conditions will be supported to self-manage their conditions and receive regular support and care in the community.

1.7 The most significant progress we have made towards the development of out of hospital services is the delivery of integrated care services through a new locality model - five locality hubs comprising GP practices working together with key partner agencies to support the most vulnerable patients. A pilot to test the concept is being delivered in the East Waverley locality, where the multi-disciplinary co-located team provides:

- Single point of access;
- Improved interface and communication flows;
- Seamless co-ordinated delivery of care.

1.8 The draft financial plan shows that the delivery of our challenging efficiency and productivity programme will enable the CCG to deliver a breakeven position in 2016/17. This does not meet the national business rule of delivering a 1% planned surplus, but our 5 year financial forecast demonstrates that the CCG are planning to deliver a 1% surplus again from 2017/18. As a result the CCG will by then be reducing the underlying deficit and we expect to be operating in a position of recurrent financial balance by the end of 2018/19.

1.9 We are a first wave RightCare partner and we will use this methodology to deliver efficiency improvements, in terms of both health gain and reduced expenditure, working with our Public Health colleagues. We have been provided with a “Commissioning for Value” pack (January 2016) which identifies that we could improve outcomes and reduce spend in the following specialties:
One of the critical success factors in achieving the above is to ensure that we commission services that are, first and foremost, informed and influenced by patients, their families and carers. An important component of our transformation programme is to strengthen the skills, behaviours and attributes that enable the local health and care economy to respond in line with the elements of Compassion in Practice.

We consider high quality primary care to be the foundation on which to build the very best healthcare for the local population. Our Primary Care Strategy recognises the need to increase capacity and be more innovative in terms of skill mix in primary care, with a focus on preventative and proactive care, particularly for the most frail and disadvantaged communities.

RSCH is working with the CCG to identify and optimise out of hospital pathways of care. We are consulting with member practices on a range of options that will lead to a primary care provision that is sustainable, easily accessible, delivered seven days per week and that will provide out of hospital services to their local communities.

We are actively working, through the System Resilience Group, to improve access to A&E standards, commission ambulatory care pathways and 24/7 Psychiatric Liaison services and improve ambulance handover arrangements. Improvements in patient flow, from the A&E department to admission and discharge, have been achieved and we will work with the RSCH to ensure the standards required for 2016/17 are achieved.

The CCG is working with the RSCH to establish robust performance arrangements to assure ourselves that all elective and cancer referrals and treatments are delivered within the standards prescribed in the NHS.
Constitution. We will support RSCH to undertake demand and capacity modelling for specialties that are under-performing, establish workforce requirements and consider alternative approaches, for example, utilising specialist practitioners and one stop shop arrangements, wherever possible, to reduce the pressures on the medical resources of the specialty.

1.15 The Cancer Strategy Delivery Group will oversee the implementation of the NICE guidelines and the development of direct access diagnostics, to improve early identification and survival rates.

1.16 The CCG is working with the Surrey Mental Health Collaborative to improve access to services for Mental Health and Learning Disability patients. This is in the context of developing a local CCG Mental Health and Learning Disability Strategy Delivery Programme Plan, to maximise access to the community and third sector provision and improve outcomes for patients.
2. Promoting, protecting and improving the health and wellbeing of our local population

2.1. Five Year Forward View

2.1.1. The NHS Five Year Forward View was published on 23 October 2014 and set out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

2.1.2. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system. The 2016/17 Shared Planning Guidance builds on this, Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 requires NHS bodies to produce two separate but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging Surrey Heartlands STP.
2.2. **About NHS Guildford and Waverley Clinical Commissioning Group (the CCG)**

2.2.1. The CCG consists of twenty-one GP practices, known as ‘Member Practices’ and was established under the Health and Social Care Act 2012, as a statutory body responsible for commissioning health care services for its population. From 1 April 2013, the CCG was licensed without conditions and became the NHS organisation responsible for the commissioning of hospital and community health services, medicines management and enhanced primary care services for the residents of Guildford and Waverley.

2.2.2. Residents and patients across Guildford and Waverley continue, in the main, to experience relatively good health and access to high quality and responsive services when they need them. We have an excellent range of local acute, mental health, community, social and primary care providers. However, we know from the health profiles for the Guildford and Waverley population, developed by our colleagues in Public Health, that there is much to do to address health inequalities in both access and health outcomes; and that there is no room for complacency when we listen to our patient, public and carers experience of care. Through our strong locally based clinical leadership and involvement, the CCG remains determined to ensure that we secure better health and care and a consistently high quality experience for those in our community.

2.2.3. As a CCG we know that in order to achieve better health and wellbeing outcomes for all of our residents and patients we need to work closely with all of our other partners, including Surrey County Council and the Borough Councils. We are fortunate in the Guildford and Waverley community to have access to a wealth of local voluntary and non-statutory organisations which, through their commitment, support the more traditionally funded services. This close community working is vital to providing high quality care and services at a time when the financial resources are, and will continue to be, severely constrained. Between all agencies we have access to central and local government resources of around £300m pounds.
2.3. **Relationship with stakeholders**

2.3.1. The conversation with stakeholders, including the public, patients, their families and carers is changing. We believe that over time the process of consultation and involvement has become formal and can be remote from the day to day lives of the local population. Effective engagement is crucial to transforming the services we commission.

2.3.2. Our approach is based on three key principles:

1. Our commissioned services must be **accessible** - *How do I get to it?* We must ensure that our local population can understand, explore and access the right service first time in a way.

2. Our commissioned services must be **appropriate to meet the needs of the patient’s, their families and carers** - *How will it affect me?* We must clearly relate our commissioned services to the day to day lives of our population based on local context.

3. Our commissioned services must be **outcome orientated** - *What difference does it make?* This means an approach that operates in real-time, demonstrates an open capture of feedback and promotes dialogue through a variety of means.

2.4. **Public and Patient Engagement**

2.4.1. The vision is to ensure that innovative, quality driven, cost effective health and social care is in place. We will commission services which reflect the needs of the local population and improve the health and wellbeing of people living in Guildford and Waverley. Our vision, values and commitments are grounded in the belief that key decisions affecting patient care should be made by health care professionals, in partnership with patients and the wider public.

2.4.2. NHS Guildford and Waverley CCG follows these key principles in undertaking its Patient and Public Engagement (PPE) activities:

- PPE underpins all CCG activities, and all CCG staff have a responsibility for ensuring it does;
- All commissioning plans incorporate PPE;
- The views and opinions of patients and the public are equally as important as professionals working with the CCG;
- Working with our partners adds value;
• We strive to engage honestly, transparently and take the time to ensure that we provide relevant background context for our patients and the public;
• We will ensure that our engagement activities are measured, and that the outcomes of our PPE activities are reported yearly in the CCG’s Annual Report;
• High quality PPE requires expertise and professionalism; we will ensure that our commissioners have access to this at any given time in place of work.

2.5. Public Engagement: What should Guildford and Waverley CCG focus on next year and beyond? (October 2015)

2.5.1. The CCG held a PPE Forum on the 22 October to ask ‘What should the CCG focus on next year and beyond?’ A big thank you to the 33 delegates who participated in workshops covering urgent care, scheduled or planned care, mental health and integrated care. The diverse range of delegates contributed a range of ideas and points of view to the discussion. This participation is essential if the CCG is to meet the health needs of the varied population that we all work so hard for.

2.5.2. The majority of delegates said that the venue was a good choice and at our PPE meeting on 3 November 2015, the Healthwatch Surrey representative heard the PPE members say that the event was an excellent afternoon. Whilst it is good to get positive feedback, there is always room for improvement. The CCG want to build on this event and forward plan three PPE Forums for April, July and October 2016 to ensure that the engagement is an iterative process that enables the public, patients and carers to be assured that we have listened carefully and either acted on the feedback or provide reasons to why we were not able to. It is critical that service development is based on the needs of the users and that Patients, their families and carers can meaningfully inform and influence service design and delivery.

2.6. Patient experience

2.6.1. This section sets out how we will achieve the highest levels of satisfaction from the users of health and care services. Describing the overall in year goals and the deliverables for our medium term plan which are required to
ensure that any service transformational change delivers high quality services that have been designed in partnership with those that use them and their carers and families.

<table>
<thead>
<tr>
<th>2016-17 deliverables:</th>
<th>Breakdown</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.</td>
<td>Maternity</td>
<td>September 2016</td>
</tr>
<tr>
<td></td>
<td>End of Life Care</td>
<td>September 2016</td>
</tr>
<tr>
<td></td>
<td>Personal Health Budget</td>
<td>September 2016</td>
</tr>
<tr>
<td></td>
<td>FFT</td>
<td>September 2016</td>
</tr>
</tbody>
</table>

Overall 2020 goals:

- Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96%), and ensure its effectiveness, alongside other sources of feedback to improve services.
- Increase the number of people who have a personal health budget or integrated personal budget.
- Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.

2.6.2. By working together under a ‘One Guildford and Waverley’ collaborative we intend to maximise the benefits from this close working. It is our collective responsibility to make sure that we spend this money wisely on behalf of our patients and residents, to achieve the best outcomes. With a more integrated approach to commissioning services, and shared joint priorities and strategies with our partners, we believe we will improve the experience of receiving care, maintain the delivery of high quality of care and meet our statutory financial obligations.
2.6.3. Whilst the CCG and our partners have much of the responsibility for delivering healthcare and support services, we know that we must enable and encourage our community to take increasing responsibility for staying healthy and managing their health and wellbeing. To this end, the Public Health Prevention Plan will be refreshed over the next few months in line with the requirements on the CCG to develop the Sustainability and Transformation Plan with key partners. GPs and other medical practitioners are crucial to supporting patients and carers in promoting self-care and independent living, but increasingly our pharmacists, social care workers and other support organisations are vital points of contact for expert advice and care. This community ownership and participation is a key factor in enabling the Guildford and Waverley communities and its CCG to live within its financial limits in the future.

2.6.4. The CCG is under considerable pressure to ensure that we deliver all of our statutory commitments within the budget that we have been allocated. We, in common with all CCGs, are required as part of this annual allocation to achieve year on year efficiency improvements often referred to as Quality, Innovation, Performance and Prevention (QIPP). Despite achieving significant efficiency savings during the past year this has been below that required to be in recurrent financial balance. In order to meet our statutory financial duties we have needed to use our reserves and non-recurrent and repayable support from neighbouring CCGs. This is not sustainable and therefore we have refocused our efforts on ensuring we work closely with all parties across Guildford and Waverley to recognise the need for us all to live within the overall resource allocation we receive. All parties believe that, whilst it is a challenge, we can achieve this through closer and more integrated working, at the same time preserving care quality and outcomes.

2.7. **Sustainability**

2.7.1. This 2016/17 Operational Plan details how we will achieve a break-even position during year one. Our strategic approach to achieving a very challenging financial efficiency target and undertaking transformational change to prepare for 2016/17 and beyond, is predicated on the following principles:

- Using the opportunities offered by out of hospital care to reduce the number of people requiring hospital admissions;
• Efficient and effective integrated care pathways, through the vehicle of our Integrated Care Partnership and the Better Care Fund. This will improve quality, reduce duplication and ‘handoffs’ and ensure a more person centred approach;
• Close attention to transactional savings, to maintain our current efficiencies;
• De-commissioning of services that do not provide value for money.
• The population of Guildford and Waverley is also a high user of private medical care and health services. Analysis from Nuffield Health highlights that around 20% of our population is covered by private medical insurance. This is one of the highest percentages nationally. In addition to this formal cover many of our residents choose to access care in the private sector through self payments. This usage helps to increase the relative proportion of NHS investment into other parts of our population.
• Ensuring that quality and equality impact assessments are performed on all service, pathway or provider changes

2.8. CCG Vision

2.8.1. The CCG is committed to ensuring that our vision to achieve innovative, quality driven, cost effective health and social care is realised. Our vision underpins our strategic and operational plans. 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. We want our patients and citizens from all parts of our community to experience a system that:

• integrates health and social care services;
• focuses on the care of individuals;
• seeks to improve health outcomes for every intervention.

2.8.2. The CCG is a committed member of the Surrey Health and Wellbeing Board and have signed up to the following vision for health and social care services:
“Through mutual trust, strong leadership and shared values we will improve the health and wellbeing of Surrey people”

2.8.3. This will mean:
- Innovative, quality driven, cost effective and sustainable health and social care is in place;
- People keep as healthy and independent as possible in their own homes with choice and control over their lives, health and social care support;
- We support and encourage delivery of integrated primary care, community health and social care services at scale and pace.

2.9. **Our Corporate Objectives**

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

2.10. **Our Local Needs  (Population data)**

2.10.1. The CCG has a registered patient population of 221,960 (Primary Care Support Service, December 2014). The population profile is weighted towards the older adult population when compared nationally. Relative to England and Wales, our population has a:
- smaller proportion of children aged 0-4;
- larger proportion of young people aged 10-19;
- smaller proportion of young adults aged 25-34;
- slightly greater proportion of older adults aged 45-64;
- larger proportion of adults aged 75+.
2.10.2. In addition, the percentage of the population of over sixty-fives will continue to grow over the next five years and is anticipated to reach approximately 20% by 2020 (with circa 4% of our population expected to be over eighty-five).

Chart 1: Projected growth of the over sixty-five population in Guildford and Waverley CCG compared with England

![Chart](image1.png)

Chart 2: Projected growth of the over eighty-five population in Guildford and Waverley CCG compared with England

![Chart](image2.png)

2.10.3. Public Health England report male life expectancy at 81.7 years and 84.9 for females in Guildford and Waverley CCG compared with 78.9 and 82.8 for England respectively for the period 2008 - 2012. The CCG has a large White/British and Christian population, with small, but nonetheless 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;
• the Gypsy, Roma and Traveller (GRT) communities as a significant minority ethnic group living in Guildford and Waverley.

2.10.4. Our service planning needs to recognise the levels of demand and capacity for dealing with the complications of complex, poorly managed, or late stage disease in secondary care.

2.10.5. This Operational Plan has been developed to demonstrate clear and realistic actions that will be undertaken to deliver improvements in the care and support of our population, and detail the targets we have set ourselves and the way in which these will be met.

2.11. Commissioning Intentions 2016/17

2.11.1. This section describes the broad direction of the Improving Value and Outcomes (Quality, Innovation, Productivity and Prevention) plan for 2016/17. The intentions are built on the CCGs’ previous Commissioning Plans and retain the key themes of ensuring that care takes place in the right setting and as close to the patient’s home as possible; patients are empowered to manage their care in partnership with health professionals; the delivery of care will be as efficient as possible whilst maintaining or improving quality.

2.11.2. The CCG is fully committed to the principles of the NHS Constitution and is committed to commissioning high quality health services, delivered in the most cost effective way for its patients. We are committed to delivering the NHS Constitution, ensuring choice and enabling shared decision making. Indeed these commissioning intentions are designed to meet the needs of our patients and population as identified in the Joint Strategic Needs Assessment (JSNA).

2.11.3. In order to achieve large scale transformation of the whole system the CCG has set out its commissioning intentions for 2016/17 which are summarised below. These include the service improvements developed during 2015/16 and will result in significant changes to some pathways of care during 2016/17 and enable improved care, through either procuring or undertaking service improvement with existing providers:
<table>
<thead>
<tr>
<th>Service</th>
<th>Target Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Community Health Services</td>
<td>April 2017</td>
</tr>
<tr>
<td>Patient Transport Service;</td>
<td>April 2017</td>
</tr>
<tr>
<td>Ambulatory care sensitive pathways</td>
<td>April 2016</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>April 2017</td>
</tr>
<tr>
<td>Primary care provided Cardiology diagnostic pathway</td>
<td>April 2016</td>
</tr>
<tr>
<td>One stop community based Urology service</td>
<td>July 2016</td>
</tr>
<tr>
<td>Children’s Allied Health Services, including Speech and Language Therapy, Occupational Therapy and Physiotherapy</td>
<td>April 2017</td>
</tr>
<tr>
<td>Integrated model for End of Life care and treatment to ensure co-ordinated, integrated care is provided to support both the patient and their carers</td>
<td>April 2017</td>
</tr>
<tr>
<td>Commission a Care and Residential Home Locally Commissioned Service</td>
<td>July 2016</td>
</tr>
<tr>
<td>Integrated Dermatology service</td>
<td>October 2016</td>
</tr>
</tbody>
</table>

**Table 1: Commissioning Intentions Target dates**

2.11.4. In addition, we will continue our work with providers to develop and achieve:

- Seven day community based services;
- Integrated Care Pathways;
- Community based Musculoskeletal, Dermatology, Pain Management and Rheumatology service.

2.6.3 For all commissioning intentions, service changes and pathway developments, a full quality and equality impact assessment will be performed as part of the standardised project management methodologies. Where impacts are identified either by project leads or the quality team, mitigating actions will be planned, and there will be close integration with the CCG risk register. Quality surveillance will then be a core component to ensure the realisation of benefit.
2.12. Plan on a page

Operational Plan - Plan on a page 2016/17

The vision is to achieve innovative, quality driven, cost effective health and social care. 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.

Outcomes framework
- Develop a population based system of care
- 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
- 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

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

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

Medicine Management Programme supports cost-effective prescribing in primary care

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

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

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

Figure 2: Plan on a Page
3. **Sustainability and Transformation Plan**

3.1. Guildford and Waverley CCG is a member of the Surrey Collaborative which is a group of the six Surrey CCGs. Guildford and Waverley CCG and hosts the Children’s Collaborative Commissioning Team for the Surrey CCGs. We are a key member of the Surrey Transforming Care Partnership, whose role is to transform the care and support for people with a learning disability and/or autism at an accelerated pace.

![Figure 3: Surrey Heartlands STP Footprint map](image)

3.2. Within this complex system, Guildford and Waverley CCG have proposed that, in order to develop a place-based, multi-year plans built around the needs of local populations, that it should work within a smaller footprint with North West Surrey CCG and Surrey Downs CCG in developing a Sustainable Transformation Plan (STP). The STP footprint, Surrey Heartlands, is the working name for the population and health services of Surrey covered by Surrey Downs, North West Surrey and Guildford and Waverley CCGs.
3.3. **Key Issues**

3.3.1. **Surrey Heartlands** requires a place based strategy that will address the following issues:

- Managing a growing elderly population with multiple long term conditions within the financial constraints;
- Delivering local integration strategies aligned to the NHS Five Year Forward View continuing at pace, including operational and budgetary integration between health and social care commissioning and provision to enable support to be placed around individuals based on need rather than the conventions of existing funding streams;
- Ensuring implementation of challenging new standards for acute hospital services. These standards are backed by evidence on quality, call for key specialties, diagnostic and interventional facilities to be located together and 24/7 consistency of senior clinical input. This is a particular challenge for emergency care, cardiovascular specialties and maternity and paediatrics;
- Supporting small to mid-sized District General Hospitals which cannot all achieve these new standards on their own. The STP needs to articulate how these sites will evolve both to support each CCG’s integration strategy and achieve nationally recognised standards for acute care, whilst balancing the need for local access to hospital-based care and maintaining financial sustainability;
- Managing the impact of patient flows to London-based tertiary centres. In many cases this is appropriate and secures high quality very specialist care for our patients. However in other areas this reduces the investment available to local teams, limits the ability to train and retain a high quality workforce and creates a fragmented patient experience. The STP needs to identify concrete, actionable opportunities to repatriate specialist services to Surrey-based hospitals;
- Developing primary care – pressures of managing the frail elderly have to be balanced with maintaining access for other patient groups, many of whose only regular contact with the NHS is via general practice. Whilst the STP cannot definitively solve this challenge, it will need to map out an approach to the development of primary care that secures improved access and the ability to take on a wider role.

3.4. **Principles and Objectives**

- The STP plan will be built up from existing local plans and reflects the strong work done in each local health system to set out a vision for the future and begin the process of implementation. The STP will address the potential supply-side implications of those plans taken in aggregate form,
and how services naturally commissioned on a wider footprint may evolve. The CCGs have existing cross-CCG working arrangements which the plan and plan development process will build on rather than duplicate;

- We recognise that there are multiple overlapping footprints and we will continue to work with other partners Surrey-wide, with Sussex, Kent and Hampshire, and south-west London. Where we can we will build these multiple levels into our STP to create a single planning document for the local system.

3.5. Governance

3.5.1. The principal governance for the STP will be through a Transformation Board and the named Senior Responsible Officer. In addition, a Committee in Common of the CCGs will be established for final signoff of the submission.

![Diagram of STP Governance framework]

Chart 3: STP Governance framework

3.6. Timeline

3.6.1. **Phase 1 - to 28th March 2016**

- Establish governance, leadership and key timescales;
- Establish workstreams and areas to be covered by aggregation of existing strategies;
- Desktop-based work will identify the current quality, outcomes and effectiveness of services in the STP footprint, using a range of sources and benchmark information that is already available and national tools;
- Demographic modelling will be applied to show the growth in demand for
services to 2020/21;

- A finance workstream will be established that will generate a comprehensive provider and commissioner model describing finance assumptions from 2016/17 to 2020/21;

3.6.2. **Phase 2 – April and May 2016**

- Synthesise information from existing plans including content, timescales, expected outcomes;
- For workstreams mobilised in Phase 1, facilitated clinical and patient engagement will take place on the challenges identified by the Phase 1 work, leading to an iterative process of identification of potential solutions, review of relevant evidence regarding effectiveness, feedback and further discussion;
- This will be an iterative process with workstreams taking the lead on drafting and owning their sections of the STP, but with a responsibility to the core team to identify dependencies across the workstreams and drive cross-workstream conversations to ensure strategic coherence;
- Finance leads aligned to each workstream will capture, in a common format, potential changes to activity and financial flows arising from both the workstream and the synthesis of existing strategies.

3.6.3. **Phase 3 – June 2016**

- Outputs of the workstreams will be aggregated in both narrative and quantitative forms;
- Finance and activity inputs will be aggregated to demonstrate the potential contribution of workstream outputs to addressing the medium-term financial challenge;
- The final narrative will be prepared and finalised.

3.7. **STP Quality Impact**

3.7.1. At all stages of development, plans will be subjected to quality and equality impact assessments. Where impacts are identified either by project leads or the quality team, mitigating actions will be planned, and there will be close integration with the CCG risk register. Quality surveillance will then be a core component to ensure the realisation of benefit.
4. Achieving Financial Balance

4.1 Financial sustainability

4.1.1 Our vision is underpinned by financial sustainability. If we can deliver the 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 a significant level of resources from the acute sector to the primary care and community sector.

4.1.2 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.

4.1.3 GWCCG plan to deliver a breakeven position in 2015/16, which will be underpinned by a level of financial support. The CCG has an underlying recurrent deficit and faces a significant financial challenge in 2016/17. The indicative net QIPP target is £12.8m which must be addressed through the Service Transformation Programme. A number of schemes are currently being scoped and implemented. The table below highlights the key areas currently under review as part of the Service Transformation Programme.

<table>
<thead>
<tr>
<th>Area</th>
<th>Headline scheme</th>
<th>QIPP 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Care</td>
<td>Ambulatory Care, Better Care Fund, Integrated Care Partnership</td>
<td>4,079</td>
</tr>
<tr>
<td>Planned Care</td>
<td>Advice &amp; Guidance, Ophthalmology / Integrated Eye Service, Wet AMD drugs, Hydration in Care homes, DVT, Dermatology, Gynaecology, Long Term Conditions, Other acute</td>
<td>2,822</td>
</tr>
<tr>
<td>Right Care Programme</td>
<td>Circulation problems, Trauma &amp; Orthopaedics, Respiratory, Renal Gastrointestinal, Musculoskeletal</td>
<td>2,006</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Contractual review of adult contract with provider</td>
<td>250</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Reboats, Care home Project, Patent expiry, Cost reductions as per Astro</td>
<td>2,000</td>
</tr>
<tr>
<td>Other</td>
<td>Corporate / Estates, Other acute contract review and contract challenges</td>
<td>750</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>12,757</strong></td>
</tr>
</tbody>
</table>

Table 2: 2016/17 QIPP Schemes

4.1.4 The draft financial plan for 2016/17 shows that the CCG is not fully compliant with the national business rules planning for the delivery of a breakeven
financial position rather than the required 1% surplus. The CCG has established a 1% non-recurrent investment reserve and a 0.5% contingency reserve, in accordance with the planning requirements, and the financial plan also includes the repayment of agreed financial support relating to 2015/16.

### Table 3: Application of funds 2016/17

4.1.5 The 2016/17 CCG allocation baseline is £246.4m, including the running cost allowance of £4.9m. This represents an uplift of 3% for growth, equating to £7.3m. The growth funding is now inclusive of a number of items previously funded separately including GP IT revenue costs and CAMHS Transformation funding which create additional financial pressure to the CCG in 2016/17.

4.1.6 The % changes adopted for growth and efficiency are summarised in table 3 below, with the impact in terms of key bridging movements detailed in table 4:

### Table 4: Growth and efficiency
4.1.7 The CCG is planning for a transfer of funding to the 2016/17 BCF in line with the 2015/16 requirements, at a value of £11.5m.

4.1.8 The CCG investment reserve of 1% non-recurrent funding is not currently committed in the plans, as per the national guidance requirements, although the process for utilising these funds is yet to be confirmed. Further investments required for any new schemes will need to cover project implementation costs before net savings are generated.

4.1.9 The CCG has funded the Mental Health outturn of costs from 2015/16 and applied growth to this funding as well as including a number of investments into the Specialist Mental Health Provider contract as well as increasing the funding for IAPT up from the outturn in 2015/16 to ensure the required levels of activity can be funded in 16/17. The impact of this is growth in funding demonstrated above the level of other general CCG growth (5.1% versus 2.9% from the table below)

<table>
<thead>
<tr>
<th>Programme Growth</th>
<th>2015/16 FOT</th>
<th>16/17 Plan</th>
<th>Growth in MH Spend</th>
<th>Parity of Esteem Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parity of Esteem</td>
<td>2.9%</td>
<td>23,934</td>
<td>25,143</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Table 5: Parity of Esteem investment schedule
4.2 Service Transformation Programme

4.2.1 The new model of integrated care has been designed to shift resources from reactive to proactive care, from hospital based to community based care, and from treatment to prevention. The cost of implementing the new integrated model will be resourced through a reduction in the hospital based expenditure for these patients.

4.2.2 In order to achieve this we need to reduce the capacity of acute inpatient beds, through decreasing the Non-Elective Admissions and excess bed days (Delayed Transfers of Care) demand. The bed capacity at the Royal Surrey will need to reduce by at least 42 beds by the beginning of the 2016/17 financial year. We are establishing ways of supporting frail patients in the community, particularly during the winter months when inpatient activity peaks.

4.2.3 In addition, several schemes established during 2016/17 to reduce the demand for elective activity are now starting to have an impact. We have been commissioning community pathways, which provide value for money, high quality service provision in a timely manner close to the patient’s home where clinically appropriate. The levels of planned activity has been lower than the 2014/15 baseline since July 2015 and it is anticipated that this will continue in to 2016/17. We continue to work with the practices to support them to understand the position and identify approaches that will support us collectively reaching the required efficiency targets.

4.2.4 Five key priority Operational Delivery Programmes have been developed. These transformation programme plans set out the service improvements for delivery during 2016/17. These plans will be further developed through the STP planning process. Each of these programmes includes a significant number of projects that will contribute to the 2016/17 challenge.

4.2.5 The priority transformation programmes are:
   - Unplanned Care
   - Planned Care
   - Medicines Management
   - Cancer
   - Mental Health, Learning Disabilities and Dementia
4.2.6 The ‘Improving Value’ projects are:

<table>
<thead>
<tr>
<th>Unplanned Care</th>
<th>Planned Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Nursing and Primary Care Services</td>
<td>Reduction in Out Patient appointments</td>
</tr>
<tr>
<td>A &amp; E Triage Service</td>
<td>Integrated Eye Care Service</td>
</tr>
<tr>
<td>Ambulatory care pathway</td>
<td>Advice &amp; Guidance across all services</td>
</tr>
<tr>
<td>PTS Eligibility Services</td>
<td>End-to-end respiratory pathway</td>
</tr>
<tr>
<td>Mental Health/Frequent Attenders Service</td>
<td>Integrated diabetes service</td>
</tr>
<tr>
<td>Hydration in Care Homes Service</td>
<td>Redesign the Urology Pathways</td>
</tr>
<tr>
<td>ICP – local pathways for Long Term Conditions</td>
<td>Audiology Service</td>
</tr>
<tr>
<td>Age UK Integrated Care—“Living Well”</td>
<td>Dermatology Service</td>
</tr>
<tr>
<td>Falls Pathway</td>
<td>Community Gynaecology Service</td>
</tr>
<tr>
<td>Community Single Point of Access</td>
<td>Cardiology Service</td>
</tr>
<tr>
<td>Frailty Initiative</td>
<td>DVT/PE locally commissioned services</td>
</tr>
<tr>
<td><strong>Medicines Management</strong></td>
<td>Minor Surgery review of LCS activity in Primary Care</td>
</tr>
<tr>
<td>Medicines optimisation services</td>
<td>Specialty Advice and Guidance</td>
</tr>
<tr>
<td>Optimising oral nutritional supplementation</td>
<td>LTC Coaching/Behaviour Modification</td>
</tr>
<tr>
<td>Optimising respiratory care</td>
<td>Chronic Pain Management</td>
</tr>
<tr>
<td>Focus on waste</td>
<td>Endoscopy</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>ENT</td>
</tr>
<tr>
<td>Direct access diagnostic pathways</td>
<td>Other Pipeline QIPP Initiatives</td>
</tr>
<tr>
<td>Promote cancer awareness</td>
<td>WET AMD</td>
</tr>
<tr>
<td>Earlier diagnosis pathways, systems of support for</td>
<td>Dermatology</td>
</tr>
<tr>
<td>patients living well with and beyond cancer</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health, Learning Disabilities and Dementia</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Surrey Crisis Care Concordat</td>
<td></td>
</tr>
<tr>
<td>Guildford and Waverley Safe Haven project</td>
<td></td>
</tr>
<tr>
<td>24/7 ageless psychiatric liaison service at RSCH</td>
<td></td>
</tr>
<tr>
<td>Personal health budgets for mental health</td>
<td></td>
</tr>
<tr>
<td>MH &amp; Dementia training and education programme for</td>
<td></td>
</tr>
<tr>
<td>primary care</td>
<td></td>
</tr>
<tr>
<td>Review and re-commission memory assessment service</td>
<td></td>
</tr>
<tr>
<td>Commission services for early onset dementia</td>
<td></td>
</tr>
<tr>
<td>Transformation of services for people with learning disabilities</td>
<td></td>
</tr>
<tr>
<td>NHS health checks for people with learning disabilities</td>
<td></td>
</tr>
</tbody>
</table>

| **Table 6: Improving Value Schemes**                  |

4.2.7 Many of these schemes have been mobilised during 2015/16 and it is anticipated that these will have a full year impact on activity. For example the Community Ophthalmology Service has commenced and activity is increasing and projected to deliver further savings during 2016/17. All schemes have been clinically reviewed through the CCG’s Clinical Forum during the scoping phase to ensure they are clinically appropriate, realistic and do not adversely impact on quality.
4.2.8 To ensure successful implementation of those projects with relatively high savings potential that are subject to complex change, a QIPP Delivery and Assurance Group was established in 2015/16 with lay member representation. This affords a discipline and rigour to project delivery and assurance, holding to account the identified clinical, financial and project lead for each project. For all projects and schemes, a full quality and equality impact assessment will be performed as part of the standardised project management methodology. Where impacts are identified either by project leads or the quality team, mitigating actions will be planned, and there will be close integration with the CCG risk register. Quality surveillance will then be a core component to ensure the realisation of benefit.

4.3 Elective Care

4.3.1 GWCCG, through understanding the health needs of our local population and on-going commitment towards transforming our services through improved outcomes, has continued to strengthen close partnerships with our clinical colleagues and partners. There continues to be significant progress in the reduction of activity levels for planned care services, but there is still considerable work to be done in order to achieve the desired targets.

4.3.2 As part of the service transformation and planning process for 2016-2020, the CCG is committed to collaborating with our clinical colleagues and partners to deliver service transformation schemes that will not only deliver the level of efficiency required across the system, but also improve the services delivered to our patients. The CCG recognises that transformation is a whole system approach which requires the commitment and responsibility of all parties, and the CCG’s approach to the service transformation programme reflects this.

4.3.3 As part of the transformation process, the CCG and RSCH have been working together to align their transformation and efficiency plans and have taken the joint view that there is one financial source feeding the system which requires joined up working in order to achieve the sustainable change.

4.3.4 Previously across Guildford and Waverley, the provision of planned care services was traditionally delivered within secondary care and through a first consultant outpatient appointment; this has now evolved into some of these services being shifted out of secondary care and into the community, in line with the CCG’s commissioning intentions and NHS healthcare agenda of providing ‘care closer to home.’
4.3.5 With the introduction of the Referral Support System, referrals are now triaged to ensure that the patients are referred to the right clinician at the right time. Although fairly new, this support system has also been successful in reducing the volume of outpatient appointments by supporting our local clinicians with advice and guidance on clinical issues.

4.3.6 Forging ahead, the CCG’s planned care strategy will focus on working with our key providers to establish and deliver a number of service and clinical care pathway improvement projects that will ensure that the activity is effectively optimised to achieve the best outcomes for the population of Guildford and Waverley.

4.3.7 The CCG has an ageing population, which will lead to more people living longer with long term conditions. Ensuring greater choice in how patients and carers receive and experience specialist advice and support to manage their long term conditions will over time increase the proportion that are confident to self-care and self-manage.

4.3.8 This will involve:

- Reducing the overall spend on both elective inpatient and day cases planned procedures after allowing for any additional referral to treatment time (RTT) generated activity
- Reducing the overall numbers of GP initiated referrals to hospital consultant services in line with the top decile performance across our CCG comparator peer group
- Reducing the overall number of internal hospital consultant to consultant referrals
- Reducing follow-up outpatient activity

4.3.9 The CCG and our acute provider are also developing approaches to optimise follow up appointments in line with NICE and locally developed and agreed clinical guidance. Both parties are working to rationalise planned care pathways to achieve effective high quality cost effective patient care that results in high levels of satisfactory patient experience and excellent clinical and service delivery outcomes. We intend to;

- Address outpatient activity globally, with the primary outcome being a whole pathway rationalisation of follow up activity across disease areas;
- Reduce follow-up activity with existing activity being converted to “if needed only”, or “remote/virtual follow-up”, or “formalised GP follow-up”. This should achieve a 15% reduction by the end of the financial year 2016;
• Reduce the volume of new & outpatients appointments through the utilisation of RSS and the implementation of ‘Advice & Guidance’ across all planned care services;
• Reduce the amount of resources being spent on planned care overall;
• Streamline pathways of care and improve the overall patients experience;
• Improve the quality and appropriateness of new referrals;
• Fully mobilise the community Optometry service;
• Jointly work with RSCH to implement a respiratory end-to-end pathway that initiates better management and prevents; emergency admissions, including medications to ensure patients receive appropriate care;
• Reduce the level of variances of renal disease across the local population and also the prevalence gap between expected and diagnosed levels of diabetes and hypertension by commissioning an integrated care pathway for diabetes patients;
• Whole system integrated approach to supporting people to self-manage effectively and also enable more patient access to palliative care;
• Explore a range of new LCS initiatives that will improve health outcomes for our local population;
• Shift the delivery of audiology services from the acute care into the community via the provision of a community adult hearing loss service which will also involve microsuction;
• Jointly work with local providers to deliver a number of behaviour change methodologies for people with long term conditions and reduce the volume of A&E attendances;
• Improve the RTT for urology patients through the implementation of end-to-end pathways;
• Commission an integrated prime model for dermatology services consisting of an end-to-end pathway for the provision of both community and secondary care dermatology services;
• Increase the level of referrals into the Community Gynaecology services therefore enabling more patients to be seen and treated a lot quicker within the community pathway;
• Improve the primary care pathway for the delivery of cardiology services thereby allowing more patients to be treated within the community using R-testing at diagnostic clinics and also supported by ‘Advice & Guidance.

4.3.10 The NHS five year forward view proposes a new care model for modern maternity services, stating that a review of future models for maternity units will recommend how best to sustain and develop maternity units across the NHS in England.
4.3.11 Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children, and on their resilience to problems encountered later in life. They are also crucial to ensuring women’s physical and mental health during this important time in their lives. Safe, high quality maternity services are fundamental in reducing the gap in infant mortality and in life expectancy.

4.4 Maternity Services

4.4.1 The NHS five year forward view proposes a new care model for modern maternity services, stating that a review of future models for maternity units will recommend how best to sustain and develop maternity units across the NHS in England.

4.4.2 Good maternal health and high quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children, and on their resilience to problems encountered later in life. They are also crucial to ensuring women’s physical and mental health during this important time in their lives. Safe, high quality maternity services are fundamental in reducing the gap in infant mortality and in life expectancy.

4.4.3 Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development; ‘physical, intellectual and emotional’, are laid in early childhood. What happens during these early years, starting in the womb, from the point of conception, has lifelong effects on many aspects of health and well-being.

4.4.4 In order to give every child the best start in life, GWCCG aims to commission high quality, evidence based and safe maternity care services, delivered at the right time, in the right place, by a properly planned, educated and trained workforce, and that women and their families have access to the services and support they need during pregnancy, childbirth and postnatal period.

4.4.5 The RSCH maternity unit was found to have outstanding leadership and standards of care by the Care Quality Commission in 2014 and has completed the refurbishment of the maternity unit now fully equipped with a
high dependency unit, new high risk area (which includes a birthing pool) and improved facilities for partners.

4.4.6 During 2016/17 we will establish Surrey wide arrangements to oversee and seek assurance that all providers of maternity services are compliant with the standards and implement the recommendation set out in the National Maternity Review findings.

4.4.7 The National Maternity Review highlights personalised care as a key priority. This will entail services reflecting on their offer to ensure women are offered genuine choice about the care they receive during ante-natal, intra-partum and post-natal periods. Guildford and Waverley CCG will work with providers to guarantee that local women are able to make informed choices about their care throughout the pregnancy pathway.

A. High level ambition for maternity:

- The National Maternity Review was published in early 2016. During 2016/17, Guildford and Waverley CCG’s will work in conjunction with RSCH to review the recommendations of the review and to determine the priority areas of focus to ensure that Surrey women and babies always achieve best possible outcomes throughout the maternity pathway.

- From a national and regional perspective, Maternity has also been identified as a key national priority area and during 2016/17 the existing Kent Surrey Sussex Maternity, Children and Young People Strategic Clinical Network will be reviewing existing work streams and refocusing resources to be focused upon maternity. CCG's will continue to remain an active partner within this network and will expect all commissioned providers to engage and support delivery within the designated priority work streams.

- Planning services across the ‘Surrey Heartlands 1’ Sustainability and Transformation Plan (STP) footprint may influence future configuration and delivery of local maternity services. Guildford and Waverley CCG Children’s Collaborative Commissioning Team are leading the Maternity and Children’s Service work stream for the STP.

B. Development/transformation ambition for the domain for the coming year:

- Full implementation of South East Coast Strategic Clinical Network recommendations to reduce preterm birth and still birth, working with acute

[^1]: denotes the working description of the area of Surrey covered by Surrey Downs, North West Surrey and Guildford and Waverley CCGs
hospitals to introduce the national Stillbirth Care Bundle. This includes maximising the opportunity for pregnant women and their partners to access smoking cessation services, with midwives testing carbon monoxide levels during the antenatal period. The local provider will audit the effectiveness of the programme during 2016/17.

- Maternity providers will also need to participate in the NHS England-led Quality Assurance process for antenatal and newborn screening during 2016/17 to ensure full compliance.
- Local maternity provider intends to develop a ‘one-stop’ service within the maternity day assessment service to improve experience and outcomes for women.

C. Current position (strength and areas of development):

- Local maternity provider is actively involved in the South East Coast Strategic Clinical Network work streams focused on preterm birth and still birth and has implemented carbon monoxide monitoring and training for fundal height measurements and customised growth charts.

D. What work has been done in this domain to date?

- Local provider has been chosen to be the only non-London maternity provider involved in the St. George’s-led research study on growth monitoring.
- Local provider has invested in carbon monoxide monitoring equipment to support testing within the antenatal pathway.
- RSCH have appointed a Antenatal Pathway Matron to lead further development within the day assessment unit service to improve the service offer.

E. Work plan for the coming 12 months:

- RSCH has been invited to participate in the St George’s’ research study on growth monitoring and is currently awaiting confirmation of which of the two pathways they will be joining. They will be the only maternity service outside of London involved in this programme.
- The Antenatal Pathways Matron will be undertaking a review of all pathways from triage to maternity assessment unit with the aim of developing a one-stop service to reduce admissions, length of stay and improve overall experience and outcomes for women.
- G&WC/RSCH will be expected to continue using the South East Coast quality dashboard, to develop an accurate and comparable overview of service delivery at a local level. It is intended that the information gathered through the dashboard will enable local CCGs and providers to identify areas of specific focus for future improvement.
4.4.8 For all projects and schemes relating to maternity care, quality and equality impact assessments will be performed as part of the standardised project management methodology. Where impacts are identified either by project leads or the quality team, mitigating actions will be planned, and there will be close integration with the CCG risk register. Quality surveillance will then be a core component to ensure the realisation of benefit.

4.5 **Productivity work programme**

4.5.1 The CCG recognises the critical importance of addressing workforce management and productivity. All areas of expenditure require close scrutiny if the efficiency challenges are to be met by the CCG and providers. The following areas are described in more detail in this section:

- Workforce
- Hospital Pharmacy and Medicines Optimisation
- Estates Management

4.6 **Workforce**

**Workforce – A Commissioners perspective**

4.6.1 The CCG has worked tremendously hard over the last year to bring about stability for its workforce, ensuring the staff are engaged and involved in building the future vision of health care commissioned for the population of Guildford and Waverley.

4.6.2 The organisation recognises, however, the financial and quality improvement challenges ahead within the system and pressures this places on the workforce, whether from a commissioning or provider perspective. To this end the CCG intends to work in partnership wherever practicable possible, sharing resources, knowledge and expertise across the system, bringing about more efficient and effective ways of working.

4.6.3 A number of measures are being implemented nationally to control provider spending, for example by reducing expenditure on agency staff. Regulatory controls are being strengthened and providers have been required to revisit their plans – which Monitor recently termed ‘unaffordable’ – to identify savings.
4.6.4 Significant emphasis has been placed on implementing the findings of Lord Carter's review of efficiency in hospitals and measuring how efficiently providers use resources. The Carter review identified only £5 billion in savings, underlining the scale of the productivity challenge facing the NHS and the need to deliver better value by taking action at all levels of the NHS to change clinical practice.

4.6.5 In response to a significant increase in the use of agency staff and contractors, new rules have been put in place to control spending. These include:

- Maximum hourly rates for agency staff
- Requirement for NHS organisations to employ staff only from agencies on approved frameworks
- Trusts in financial difficulty, applying a ‘ceiling’ (on a trust-by-trust basis) to total spend on agency staff.
- A business case is approved by NHS E for any off-payroll contracts lasting longer than 6 months in duration and/or costing more than £250 per day

4.6.6 As highlighted in the report on workforce planning in the NHS published April 2015, the increasing reliance and spend on temporary staff is a result of a more fundamental problem – the lack of permanent staff. The following areas need to be addressed to secure a sustainable workforce for the local health and care economy:

- Mental health staff;
- Primary Care – GPs, practice nurses;
- Nursing and Allied Health Professionals;
- Care worker staffing groups.

4.6.7 The CCG will work with its providers throughout the year to better understand their workforce issues and support the development of a collaborative approach, aligning strategies to improve recruitment and retention; enhance performance through developing ambition and managing talent; sign-up and implementation of the health and wellbeing charter to ensure the workforce is nurtured in a culture that promotes meaningful workplace wellbeing for staff.
4.6.8 Good practice in workforce management will be a key factor in returning the system to a sustainable position. Addressing the challenges amidst such demands to reduce spend and increase productivity is going to be difficult. The CCG will work with the local health and care economy to assure a workforce development improvement plan addresses the following objectives:

- Improve recruitment and retention rates;
- Reduce absence rates;
- Reduce agency and off-payroll dependencies
- Achieve appropriate headroom levels;
- Review flexible working arrangements;
- Commitment to health and wellbeing initiatives (and the health and wellbeing charter)
- Improve shift working resourced through substantive staff;
- Develop whole system workforce planning, succession planning and managing talent;
- Agree an effective and efficient model to monitor workforce KPI’s and their direct association with broader organisational strategies and plans;
- Explore opportunities for workforce portability, and innovative solutions for ‘hard to fill’ posts;
- Identify common market and local workforce trends in staff survey results and look at shared resources/best practice in areas of focus
- Improve compliance with appropriate staffing levels and skill mix for professional groups, particularly ward types in response to the standards set out in the RCN and NICE guidelines;
- Review the demand and supply of additional nursing capacity, particularly with respect to specialist mental health care.

4.7 Hospital Pharmacy and Medicines Optimisation

4.7.1 Medicines optimisation is a new and patient-centred approach to achieving best outcomes and value from medicines. This will form a significant element of the identified efficiencies that will enable us to achieve financial balance during 2016/17 and will build on its excellent track record in doing so.
4.7.2 At a local level with neighbouring CCGs, the GWCCG Medicines Management Team (MMT) lead on the adaptation and agreement of the primary care Management of Infection Guidance which is based on the Public Health England (PHE) template.

4.7.3 For 2016/17 the plan is to continue to focus on antibiotic prescribing through the Local Prescribing Scheme (LPS). This will build on the work that was already undertaken as part of LPS, which in turn supported the objectives for the Quality Premium on patient safety and antimicrobial prescribing in primary care.

4.7.4 The networks with neighbouring CCG Medicines Management teams will continue to be developed to further enhance the 2015/16 audit which will report against the following indicators:
   - Items/STAR-PU (prescribing volume measure)
   - % High risk antibacterial

The quality premium includes antibiotic prescribing as part of improving patient safety. There is recognition that antimicrobial resistance (AMR) and antibiotic prescribing are inextricably linked and in turn AMR is a major threat to the delivery of safe and effective healthcare. The LPS supports delivery of specific actions at practice level and the prescribing data will allow monitoring of prescribing data at both practice and CCG level; this will include benchmarking across organisations.

4.8 Estates Management

4.8.1 The Strategic Estates Plan (SEP) will set out how the existing estate will respond to the clinical aspirations of the CCG. The SEP will respond to the guidance issued by the Department of Health in June 2015, as updated in September 2015. The SEP is being prepared by NHS Property Services. The document will set out an understanding of the issues that will progress strategic estates planning within the CCG and, most importantly, identify an action plan to progress this.

4.8.2 We recognise that achieving the efficiencies required by the Five Year Forward View (5YFV) will mean all parts of the health service will need to work with greater agility and co-operation. The Strategic Estates Plan will enable the NHS to:
   - rationalise its estate;
• maximise use of facilities;
• deliver value for money;
• afford quality provision of services from suitable location;
• enhance patients’ experiences.

4.9 Reducing Health Inequalities

4.9.1 During the first year of the STP it is imperative that we develop proactive interventions that will support our local population to improve their health and wellbeing. This will reduce the health inequality gap and also translate into less demand on the health and care system.

4.10 Analysis of high impact areas of improvement

4.10.1 The five most cost effective, high impact interventions identified by the National Audit Office (NAO) report of health inequalities that will improve the health of our population and reduce health inequalities are:

• Increased prescribing of drugs to control blood pressure;
• Increased prescribing of drugs to reduce cholesterol;
• Increase smoking cessation services;
• Increased anticoagulant therapy in atrial fibrillation;
• Improved blood sugar control in diabetes;

4.10.2 Using the Joint Strategic Needs Analysis (JSNA) and the Commissioning for Value (CfV) pack, we have identified that our population has significantly greater rates of years of life lost due to premature mortality for trauma/injuries.

4.10.3 It is essential that we review not only the activity levels but ensure that we are focussed on outcomes and whether these have been achieved by the delivery of a high quality service. Ensuring that patients have the option to make an informed preferred decision regarding their future health care.

4.10.4 We have significantly high elective and non-elective admissions for people with cancer, circulatory and respiratory diseases. Currently the prevalence of diabetes is not significantly high, but with high levels of obesity in our population, the projections show a significantly high increase in diabetes prevalence over the coming years. We are also aware that increased focus on diabetes will improve cardio vascular outcomes. We are benchmarking
our data by carrying out public health analysis on A&E admissions, top 5 reasons for attendances and conducting statistical process analysis at CCG level, to compare trends in our population with other areas.

4.10.5 Additionally, we are reviewing the growing morbidity in comparatively younger populations compared to previous years. Analysis regarding the JSNA is currently underway, including strengthening data to support the delivery of the Children’s and Families Act for 0-25 year olds.

4.10.6 We will prioritise integration of respiratory services to improve the health of patients with respiratory illnesses and reduce hospital admissions by improving care in the community, early diagnosis and interventions and work towards reduction in the smoking prevalence. Providing the critical establishment to achieve high quality consistent delivery of care.

4.10.7 We are working to integrate the diabetes nursing provision through the community procurement opportunity; this will provide specialist support and training, to primary care and improve the management for patients with diabetes in the community. We are working with the specialists to outreach into the community, making them more readily accessible to primary care and patients. We are also working with Public Health to reduce the prevalence of smoking and obesity in our population, particularly in areas of greater deprivation.

4.10.8 A higher proportion of the population will be in the age group who are developing chronic diseases, including obesity and diabetes, hypertension and cardiovascular disease, and chronic obstructive pulmonary disease (COPD). Adopting a preventative model will mitigate early disease through behaviour modification (smoking, diet, exercise, and alcohol) and form the foundation of managing the health of these individuals. In addition, 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) will reduce the demand on the emergency health and social care services.

4.11 RightCare

4.11.1 The Guildford and Waverley local health and care economy has been selected for the first wave of RightCare support. The primary objective is for the CCG to work with RightCare to maximise value:
• the value that the patient derives from their own care and treatment
• the value the whole population derives from the investment in their healthcare

4.11.2 RightCare is a key and essential element of the G&W local health and care economy transformation and it will contribute to the development of the:
• Financial strategy;
• Commissioning strategy;
• Methodology for QIPP delivery over the next 3 years.

4.11.3 RightCare will provide us with a systematic QIPP methodology, ensuring that quality and equality impact assessments are completed for any service transformation, achieving standardised delivery and reduce risk and increase repeatability. The methodology utilizes a systematic approach which includes the following five stages:

• Deep Dive;
• Gap analysis;
• Action Planning;
• Implementation;
• Quick win and full delivery.

---

**Figure 5: Rightcare process flow**

1. RightCare identifies what to change by breaking down high level opportunity and identifying tangible themes that can be delivered

2. Gap analysis links the quality and cost indicators to current practice and researchs where best exists. Stakeholders will be invited to join the STP project teams to close the gap

3. Having agreed the gap STP project team will build the action plan and develop assured project initiation documents

4. Implementation is the roll out stage prior to benefit delivery, this will include physical pathway change, new commissioning policies and contract variation orders, etc.

5. Benefit realisation mechanisms including evidence capture and reporting will be developed during the action planning stage to ensure delivery isn’t delayed
4.11.4 Adoption of the RightCare Approach will help us to optimise the five key ingredients of improvement in healthcare systems so that achievement of better population healthcare is, in turn, also optimised.

4.11.5 These key factors for achieving system transformation via RightCare are:
- Clinical leadership of the improvement agenda leading to higher quality service delivery;
- Use of indicative data to identify (Where to Look);
- Clinical engagement in designing optimal pathways and systems (What to Change);
- Use of evidential data to build the case (What to change);
- Optimal utilisation of improvement processing to ensure that the healthcare pathways and systems that are designed locally, proven viable and achievable, are delivered.

4.11.6 The Commissioning for Value pack published in January 2016 identifies that we could improve outcomes and reduce spend in the areas detailed in the diagram below:

![Spend & Outcomes Diagram]

**Figure 6: Rightcare spend and outcomes**

4.11.7 The report establishes that there are potential savings in elective and non-elective activity in the following specialties:
- Respiratory
- Mental Health
- Neurological
- Circulatory
- Musculoskeletal
4.11.8 The CCG is working with our RightCare delivery partners to develop an effective methodology. The CCG has established full engagement with clinicians across the relevant sectors of health provision, including primary care clinicians, acute specialists and service transformation management to establish service improvement plans that will deliver improved quality of service delivery, improved outcomes and increased efficiencies across the system.

4.11.9 The CCG will work with existing patient and public reference groups and voluntary sector organisations to ensure that we achieve a consensus of the issues and a coproduction of the solution.

4.12 Maternity

4.12.1 A major review of maternity services across the Kent Surrey and Sussex Maternity, Children and Young People Strategic Clinical Network will be reviewing existing work streams and refocusing resources to be focused upon maternity local health economy in Surrey during 2016, in order to address the recommendations of the National Maternity Review. The expected outcomes are aimed to also address the pressures on capacity, workforce, promoting choice of place of birth (including at home or in midwifery-led units) and ensuring improved safe birth for the most complex presentations.

4.12.2 The Surrey Heartlands STP have identified Maternity and Paediatrics and one of the workstreams and this will develop a 5 year ambitious plan of how we improve Maternity Services across the three CCGs of Guildford and Waverley, Surrey Downs and Northwest Surrey. This opportunity to work collaboratively across the commissioning and provider environment opens up the discussion and may result in the reconfiguration and delivery of local maternity services. High on this agenda is to assess the current maternity care and perinatal services, including support for mothers experiencing perinatal mental health issues. We will consider in partnership with service users, how services should be developed to meet the changing needs of women and babies. It is anticipated that proposals will be made to shape future services to ensure that they are personalised, family friendly, safe,
high quality kind and professional delivery resulting in high levels of patient satisfaction.

4.12.3 To support the improvement in maternity services, a number of specific developments will be implemented in-year including improved patient experience, greater choice of place of birth, support to vulnerable women and addressing issues to improve perinatal mortality.

4.12.4 We will work across the maternity service network to achieve full implementation of South East Coast Strategic Clinical Network recommendation to reduce preterm birth and still birth. The CCG are actively working with the acute hospitals to introduce the national Stillbirth Care Bundle, maximising the opportunity for pregnant women and their partners to access smoking cessation services, with midwives testing carbon monoxide levels during the antenatal period. The local provider will audit the quality and effectiveness of the programme during 2016/17;

4.12.5 We will work with RSCH to support the implementation of the NHS England-led Quality Assurance process for antenatal and new-born screening during 2016/17 and achieve full compliance, and commission a ‘one-stop’ service within the current maternity day assessment service to improve experience and outcomes for women. Recent investment into an Antenatal Pathway Matron will ensure that this development is of high quality with clear pathways of care and lines of accountability.

4.12.6 RSCH is actively involved in the SEC SCN work streams focussing on preterm birth and still birth, they have invested in carbon monoxide monitoring equipment and implemented CO monitoring, in addition increasing quality of surveillance through training practitioners to complete fundal height measurements and customised growth charts. This has developed a strong and stable foundation and resulted in RSCH being the only non-London maternity provider to be involved in the St Georges Hospital research study on growth monitoring.

Work plan for the coming 12 months:
- RSCH has been invited to partake in the St Georges research study on growth monitoring and is currently awaiting confirmation of which of the two pathways they will be joining. They will be the only maternity service outside of London involved in this programme.
• The Antenatal Pathways Matron will be undertaking a review of all pathways from triage to maternity assessment unit with the aim of developing a one-stop service to reduce admissions, length of stay and improve overall experience and outcomes for women
• G&WCCG/RSCH will be expected to continue using the South East Coast quality dashboard, to develop an accurate and comparable overview of service delivery at a local level. It is intended that the information gathered through the dashboard will enable local CCGs and providers to identify areas of specific focus for future improvement.
5  **Sustainability and Quality of General Practice**

5.2 We see high quality primary care as the foundation on which to build the very best healthcare for the local population. In order to achieve this we will need to increase capacity and capability in primary and community health services so that we can focus on preventative and proactive care, particularly for the most frail and disadvantaged communities.

5.3 Services offered by GP practices are variable and GPs are facing considerable pressure due to the rising demand for services and the increased complexity and higher expectations. Changing the way primary care operates is essential to manage high risk patients in the community. Over the next 3 years the CCG will have an increased role in commissioning a broader range of local services and supporting practices to work together to improve the quality and range of integrated services delivered, through more efficient and effective processes. Access to services seven days a week will be required, with increased use of online facilities.

5.4 The CCG will set out, in the Guildford and Waverley Primary Care Strategy, the long term ambition and vision for Primary Care. It is critical that this informs the opportunities available through the Primary Care Transformation Fund to secure investment in key enablers for integrated primary care service, namely estates and IM&T.

5.5 The strategy has, as part of its core focus, the maintenance and improvement of quality, and what is required to achieve this by both the member practices and the CCG Quality team.

5.6 Health practitioners will be able to support and advise their patients through technological solutions, such as web based face to face interactions, reducing travel time will increase the ‘time to care’ and improve ‘continuity of care’ as practitioners can follow up patients in the community.

5.7 The integrated proactive care teams will be able to utilise the locality hubs as bases from which to concentrate skills and resources, offering a wide range of assessments, diagnostics and treatment close to the patient’s home.
5.8 New models of care

5.8.1 In order for the Primary Care Strategy to be effective the CCG is engaging with member practices (for example, a bi monthly Practice Council meeting at which all 21 practices are consistently represented) and the Local Medical Committee to provide an opportunity for member practices to shape the future provision of primary care, ensuring high quality and sustainability beyond 2020.

5.8.2 We will work with the whole system to develop new models of care that form the core of the Sustainability and Transformation Plan and reflect the long term ambition which the CCG will be developing over the next 6 months with its member practices and local stakeholders.

5.9 Access to local speciality services

5.9.1 The shift in commissioning intentions will result in more health care investment and resource in the community. If this is to be invested in General Practice we need to ensure that this care is available to the whole community. This will require a significant change to the current method of commissioning services such as the Locally Commissioned Services (LCS) where each practice elects whether or not to provide these services. We propose to organise a commissioning arrangement so that agreed changes in service provision are accessible to the whole population and available in all practices. Equality analysis, which has been embedded into the commissioning cycle, will be a key tool in facilitating this process.

5.10 Community beds

5.10.1 In parallel with our aspiration to reduce acute hospital activity, we will develop systems that facilitate better use of care homes beds which will be supported by primary care and community health service provision. We will review the community hospital bed capacity and establish pathways for community and nursing home ‘step up’ beds, for patients who do not need the intensity of an acute hospital, and as ‘step down’, for use when the patient is medically fit for discharge from the hospital setting.

5.11 Workforce
5.11.1 Many GPs would ideally like the traditional way of working to remain and to preserve their role in delivering a high quality and valued service to patients in the local community.

5.11.2 However, if we look at the available workforce both nationally and locally, it is clear that the numbers of doctors coming out of medical schools over the next five years is reducing, and with General Practice not being the preferred choice for many medical students the primary care medical workforce will not be sufficient to meet the increasing demand for primary care medical services. This is in addition to the increasing acute hospital medical staffing capacity, resulting in a workforce crisis for General Practice. This is already evident in many areas of the country and is just starting to become an issue for Guildford and Waverley which has hitherto enjoyed comprehensive access to General Practice.

5.11.3 Demand is continuing to increase due to the growing population and the increasing proportion of older frail patients with multiple co-morbidities. Add in the national ambition to provide 7 day working in General Practice by 2020 and it is clear that the current model is not sustainable.

5.12 Workforce development

5.12.1 It is predicted that practices of the future will have a greater skill mix with more nurse specialists, more pharmacists, more physician assistants and health care assistants meeting the lower level health care needs of the local population. General Practice needs to consider where these skills could be best used, meeting the needs of patients with long term conditions or in the provision of urgent care.

5.12.2 It is envisaged that the role of the GP will change to assume a specialist GP role, managing complex care with a focus on preventative care for the most vulnerable population groups.

5.12.3 A team based approach to the delivery of care is imperative in meeting the needs of the population and ensuring that the multidisciplinary team share and encourage evidence based practice and compassionate care.

5.12.4 Inequalities in access to general practice have been a concern and we will explore mechanisms to allow patients to access care through alternative means, potentially via community pharmacists and the
voluntary sector. This may also include, at certain times, being able to see members of the General Practice team at premises other than their registered practice.

5.12.5 The challenge for General Practice is to review and consider whether, as separate organisations, they can sustain the infrastructure and range of opportunities to deliver the career pathways, career progression and succession planning required to meet the demands of the future. Will they need to work closer together or merge to create an attractive employment environment that improves recruitment and retention of key staffing groups, such as practice nurses?

5.12.6 The emerging Primary Care Strategy has identified that Practices will develop expanded practice-based primary care teams collectively, so that a wide and comprehensive clinical team (for example physiotherapists, minor illness nurses, paramedic practitioners, clinical pharmacists, physicians’ assistant, mental health practitioners) become the default first point of contact for patients. Through implementing this option the role of the GP would evolve to become that of clinical lead to the wider team with a focus on complex case management. The CCG expect to support this work, possibly in association with other partners such as the GP Federation.

5.12.7 There are a number of key elements to this work stream which include:
   a) Baseline and annually updated Primary Health Care workforce training requirements gathered through the primary Care workforce tool;
   b) A comprehensive training and development programme for present staff to ensure accreditation is developed and maintained for all General Practice services;
   c) A programme to recruit individuals from Surrey where possible, i.e. those most likely to remain in Surrey;
   d) A programme to recruit individuals from Surrey where possible and train them locally as HCAs and practices nurses;
   e) A programme to encourage and support those living in the area with suitable qualification but not working or only working part time to return to work/increase their working hours; and
   f) A programme to attract trainees and fully trained professionals to work in Guildford and Waverley.

5.12.8 GP practices will work together to combine workforce planning on a wider scale with CCG involvement to develop new shared models of care with possible rotation of roles through primary and secondary care The CCG will
facilitate resources and specialist elements through practices, federation or other model.

5.12.9 The CCG will work with the GP Federation to develop a plan for this priority. This will include exploring workforce models from elsewhere. This may include rotation of roles through primary, community and secondary care.

5.13 Seven Day Access

5.13.1 A voluntary new GMS contract will be introduced in 2017 to deliver 7-day care for all patients by 2020. Improved access will include appointments in the evening, at the weekend and by phone, on-line and other means. The new contract will focus on integration with community nurses and other health care professionals, to provide more seamless, person-centred care for patients.

5.13.2 The new contract will be voluntary, with federations or practices that cover 30,000 patients as a minimum. GPs will need to work in local neighbourhood surgeries and health centres, with all the traditional benefits of family practice but also join forces with neighbouring GPs to form federations or networks of practices, allowing integrated care and closer working with other health professionals.

5.13.3 GP core hours are being looked at nationally and Simon Stevens, Chief Executive NHS England, has articulated that in his opinion 8 am to 6.30pm and Saturday mornings is core General Practice, but that General Practice should be open 7 days a week in some form by 2020. The core hours will be agreed at a national level, how we deliver the out of hours General Practice and the following options will be for local determination to deliver seven day services:

- Individual practices (21)
- Localities (5)
- Rationalise locality hubs to match the Borough council footprint (2)
- Single urgent care centre (1)

5.14 Local Primary Care Estate Strategy

5.14.1 The objectives set out in the NHS Five Year Forward View directly impact on the local estate, for example a fundamental shift of core services from
secondary care provision into the community, and integration of community health and social care based upon a single point of access.

5.14.2 Estates are currently managed jointly by NHS England and NHS Property Services. The quality of GP premises is variable. To maximise the impact of out of hospital services, it is essential the decisions on location of services are made locally.

5.14.3 The Local Estates Plan will set out the strategic ambition for the CCG and will need to take into account the infrastructure requirements for the new model of care that is agreed upon.

5.14.4 The proposed merger between the two secondary care providers Ashford and St Peters Hospital and Royal Surrey County Hospital has been paused. The merger had been designed to afford the acute providers with the opportunity to consolidate the estate portfolio and may be able to provide investment opportunities.

5.14.5 The Primary Care Transformation Fund and other capital investment opportunities will help GP practices to consider the estates strategy for the future and achieve convenient access to clinical services by extending existing GP premises to provide modern facilities with disabled access.

5.14.6 The CCG is submitting an application to both Primary Care Transformation Fund in April 2016 to develop options to extend and improve access to population groups who may have experienced difficulty in accessing GP appointments previously. The development of a wider range of services in Primary Care will ensure that:

- All patients have equal access to a wide range of out of hospital services which meet their needs locally, seven days a week;
- Pathways are joined up, enabling patients to remain healthy, independent and at home for as long as possible;
- Partner organisations, such as mental health services, social care and voluntary services can be coordinated and integrated.

5.14.7 The application for Primary Care Transformation funds will be dependent on the preferred seven day service option selected and we will submit an application for capital investment.
5.14.8 Our priorities are for any infrastructure investment to support:

- Joint working between practices to support the new models of care;
- Priority to areas (especially deprived areas) where there is currently poor coverage.

5.14.9 The CCG need to be cognisant of local plans for residential developments and a Local Estates Forum has been formed with members from across the whole system to maximise the utilisation of the existing estates, agree future strategic development and reduce duplication of capital development.

5.12.10 Practices with low levels of registered patients will find the logistics of delivering high quality care increasingly difficult over the next decade. They may need to work more closely with their neighbouring practices to address how and where they deliver primary care services. The CCG would not support the creation of any new practice that has less than 10,000 registered patients.

5.15 Education & Training

5.15.1 Robust and achievable workforce plans must be developed that will support the delivery of sustainable Primary Care in the future. Workforce redesign and development of the Primary Care workforce will ensure that staff have the necessary competencies and capability to provide out of hospital care and are up to date on evidence-based treatments and technological developments. Training programmes which address key knowledge and skills gaps will need to be delivered whilst maintaining continuity of care.

5.16 IM&T

5.16.1 We want to make better use of the potential that the electronic GP record has to maintain and improve quality of care. To do this we will support practices to make best use of GP Systems, including support for:

- Collaboration
- Innovative ways of working
- Training
- Data Quality / safety
- Health Intelligence
- Care Planning
• Sharing care plans with other services (where the patient consents) and with the patient.

5.16.2 Shared access to patient clinical notes is a critical enabler of the new models of care, requiring careful consideration of information governance and the need to overcome limitations of the variant systems in place. A programme of IT development in Primary Care will enable services to work together in a more integrated way to manage patient care, provide continuity and avoid duplication.

5.17 **Quality of Primary Care**

5.17.1 Guildford and Waverley CCG is responsible for supporting GP Practices to improve patient quality of care, improve patient experience, work to reduce variability and improve clinical outcomes and quality for its registered population. Quality and safety in the delivery of health services is a fundamental responsibility, with systematic consideration of clinical effectiveness, patient experience and patient safety.

5.17.2 We will be open and transparent about the variable quality of primary care in the area and, where appropriate, publish quality information on our website. The CCG has developed a quality assurance tool shaped by our member practices and the outcome of the preventing premature mortality audit. We will use this tool to inform peer to peer discussions and drive consistent high quality care across the area.

5.18 **Practice Support Visit Programme**

5.19 A programme of practice support meetings is in place with the aim of reviewing practice progress and outcomes (both activity and quality), to analyse practice data and relate this to the GWCCG health economy, including the local QIPP programme.

5.19.1 The focus of the dialogue is the practice contribution to the overall CCG’s achievement against plan, joint development of ideas on how to plan to manage secondary care activity and prevent growth in unplanned admissions. These visits are designed to be productive and tailored to the practice needs.
5.19.2 Practices value the support given by the CCG and the opportunity to discuss ideas and concerns, whilst celebrating the positives that exist within their Practices. Data is viewed as a positive way to measure success, benchmark performance and identify areas for improvement.

6 Reducing demand on emergency services

6.1 During 2015/16 we have successfully supported the system to reduce A&E attendances within our local acute provider (RSCH) through:

- Whole system focus on pathways of care through the System Resilience Group and the Better Care Fund Local Joint Commissioning Group;
- Commissioning the Primary Care-based Frailty Initiative that supports frail older people in their local community and uses high quality proactive anticipatory care planning that is used by the emergency services. This has significantly reduced unnecessary ambulance conveyances.
- Improving discharge pathways and significantly reducing excess bed days.

6.2 However, RSCH performance for the A&E maximum four hour waits for Quarter 2, 2015/16 was below the expected standard. The CCG will continue to work collaboratively with the acute, community and social care providers and the System Resilience Group to help improve the flow of patients through the A&E department. In particular this is focused around improving the ambulatory care pathway and other subsidiary areas identified in the NHS ECIST specific work plan that has been identified with RSCH.

6.3 Better Care Fund

6.3.1 The Guildford and Waverley Better Care fund is focussed on providing commissioning integrated provision that will reduce emergency admissions and delayed transfers of care. Structure reform within the local authority resulted in the Surrey County Council establishing Area Director posts which has resulted in strong and trusting relationship being built and the opportunity to truly move the integration commissioning forward.
6.3.2  In parallel with our aspiration to reduce acute hospital activity, we will collectively develop systems that facilitate better use of care homes beds, which will be supported by primary care and community health service provision. We will review the community hospital bed capacity and establish pathways for community and nursing home ‘step up’ beds, for patients who do not need the intensity of an acute hospital, and as ‘step down’, for use when the patient is medically fit for discharge from the hospital setting.

6.3.3  By commissioning services through the Better Care Fund pooled resources we will be able to address the holistic needs of the whole person and their family. Deep dive reviews of all Better Care Funded commissioned services have commenced and will be fully completed by the end of September 2016. We need to jointly commission services designed to support patients either to remain in their normal place of residence or return to the community, supported by a robust needs-based care package.

6.3.4  This will empower our residents to manage their own health, and make the right choices about accessing urgent care services when it is appropriate to do so.

6.3.5  The Better Care Fund commissions the following services:

- Hospital based Social Services Worker facilitating discharge
- Rapid Response- supporting patients
- Telecare service in patients home
- Telehealth to support patients to self-manage
- Interface Geriatricians working across the acute and primary care sector
- Virtual Wards in primary care – frequent periodic review of the most complex patients in the community
- Social Care Reablement helping patients to learn how to accommodate their illness
- or condition and remain independent at home
- Community Equipment Service (CES) providing equipment to facilitate discharge
- Occupational Therapy provides support to patients whose health prevents them from doing the activities that matter to them.
- Enhancing End of Life Care through resourcing a central point of coordination for palliative care services
- Carers Universal Benefit Service Contract providing advice for carers
- District & Borough Council Services – supporting Mary Francis Trust, Richmond Fellowship, Surrey alcohol and Drug advisory service, Walton and Weybridge advocacy Group and Woking Mental Health Resource Centre.
- Social Care Reablement and Carers - Mental Health Community Connections.
- Terrence Higgins Trust supporting patients with HIV/AIDS
- Dementia Care Navigators – guiding patients families and carers through the system
- Psychiatric Liaison Services – enhancing access to psychiatric services in the Emergency department

6.3.6 The Integrated Care Partnership, now known as, ‘My care, my choice’ (MCMC) is Guildford and Waverley’s local health and social care system’s integration programme which is to support frail older people in the community. The model of care is based upon the needs of frail older adults for two reasons:
- Frail older adults account for high volume use of social care, acute and community health services;
- Frail older adults are more likely to have complex needs and the system redesign will support them in regaining or retaining independence in their local community.

6.3.7 MCMC’s vision is to have more intensive management of the frail older over time with more resources focused on supporting this group of patients in the community and preventing acute hospital admission. Currently the patient and carer experience of services is confusing and disjointed resulting in a poor experience. MCMC will bring together services in a more streamlined manner, and improve experience for patients and carers, and allow for easier navigation for professionals working with the frail and older population.

6.3.8 The Integrated Proactive Care Pilot in East Waverley has been extremely successful with significant reductions in ambulance conveyance rates, A&E attendances and non-elective admissions. During 2016/17 we will stretch the delivery area to include the Haslemere locality and establish an Integrated Proactive Care Service in Guildford. The community health service provider is acting as the lead provider and we jointly invested in to management/clinical capacity to roll out the pilot to the whole of Guildford and Waverley.
6.4 Urgent Care

6.4.1 The delivery objective is to further develop an accountable integrated urgent care system that is responsive to patients and carers in crisis and delivers care in the most appropriate way. The CCG is working with system resilience groups and the urgent care networks to implement the 8 high impact actions for resilience planning. Working with partners, as part of the urgent and emergency care network, towards implementation of new models of emergency care delivery and use of CQUINs to implement the findings of the urgent and emergency care review. The following schemes make up the Unplanned Care Programme that will contribute to the Urgent Care Programme Plan:

<table>
<thead>
<tr>
<th>Unplanned Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home Nursing and Primary Care Services</td>
</tr>
<tr>
<td>A &amp; E Triage Service</td>
</tr>
<tr>
<td>Ambulatory care pathway</td>
</tr>
<tr>
<td>Ambulance 75% Target</td>
</tr>
<tr>
<td>Mental Health/Frequent Attenders Service</td>
</tr>
<tr>
<td>Hydration in Care Homes Service</td>
</tr>
<tr>
<td>ICP – Defined local pathways for Long Term Conditions</td>
</tr>
<tr>
<td>CHC Project</td>
</tr>
<tr>
<td>Falls Pathway</td>
</tr>
<tr>
<td>Community Single Point of Access</td>
</tr>
<tr>
<td>Frailty Initiative</td>
</tr>
</tbody>
</table>

Table 7: Unplanned Care programme projects

6.5 Access standards for A&E and ambulance waits

6.5.1 Supporting the system to reduce A&E attendances within our local acute provider (Royal Surrey County Hospital NHS Trust (RSCH)) through:
- Whole system focus on pathways of care through the System Resilience Group and the Better Care Fund Local Joint Commissioning Group;
• Commissioning the Primary Care based Frailty Initiative that supports frail older people in their local community and high quality proactive anticipatory care planning that is used by the emergency services; this has significantly reduced unnecessary ambulance conveyances;
• Improving discharge pathways and significantly reducing excess bed days.

6.5.2 In parallel with our aspiration to reduce acute hospital activity, we will develop systems that facilitate better use of care homes beds which will be supported by primary care and community health service provision. We will review the community hospital bed capacity and establish pathways for community and nursing home ‘step up’ beds, for patients who do not need the intensity of an acute hospital, and as ‘step down’, for use when the patient is medically fit for discharge from the hospital setting.

6.5.3 One of the 9 ‘must do’s’ for 2016/17 is to get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

6.5.4 Following publication of the Keogh Urgent & Emergency Care Review, the has been established to provide strategic oversight of urgent and emergency care over the local major trauma network area. The current structure for managing unplanned care is set out below to show how the individual trust performance feeds up into the System Resilience Group which is part of the Urgent Emergency Care Network which is now aligned to the STP footprint of Surrey Heartlands.
Member Systems Resilience Groups (SRGs) maintain responsibility for the operational leadership and coordination of those local services, coming together with partner SRGs in Surrey to form the UECN ensuring coordination of the overall urgent and emergency care strategy to:

- Create and agree an overarching, [medium to long term] plan to deliver the objectives of the Keogh Urgent & Emergency Care Review;
- Designate urgent care facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health;
- Make arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals);
- Maintain oversight and enable benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries;
- Achieve resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across SRG boundaries);
- Coordinate workforce and training needs: establishing adequate workforce provision and sharing of resources across the network;
- Ensure the building of trust and collaboration throughout the network; spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

**Guildford and Waverley System Resilience Group (G&W SRG)**

The G&W System Resilience Group brings together acute, community, mental health and ambulance service providers with social care, to work collaboratively on the development of strategies and plans that ensure system-wide resilience. The SRG is supported by NHS England and has recently revised the performance reporting through the development of a whole system dashboard, which is presented monthly. Daily reports to the CCG establish the position of the system and enable early intervention to avoid wherever possible the system deteriorating into a position where it is unable to meet the demand.

The, RSCH performance for the A&E maximum four hour waits for Quarter 3, 2015/16 was below the expected standard. The CCG will continue to work
collaboratively with the acute, community and social care providers and the System Resilience Group to help improve the flow of patients through the A&E department. In particular this is focused around improving the ambulatory care pathway and other subsidiary areas identified in the NHS Emergency Care Intensive Support Team specific work plan that has been identified with RSCH.

6.5.8 The table below sets out the critical milestones and deadlines of the A&E improvement plan required for the RSCH to reach to agreed trajectory of recovering the 4 hour performance compliance:

<table>
<thead>
<tr>
<th>Critical Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint implementation of the RSCH Emergency Floor Plan. The key development areas are adjustment of workforce hours to increase Consultant cover. RAT, streaming and triage are the key work streams to improve patient experience and 95% target</td>
<td>June 2016</td>
</tr>
<tr>
<td>Implementation of a new Ambulatory Care Unit to agreed service specification. The unit will reduce non elective admissions and improve patient flow within A&amp;E</td>
<td>June 2016</td>
</tr>
<tr>
<td>SRG data improvements are designed to improve models of surge planning and response to whole system pressures. The data set now looks at the weekly patterns and creates dashboards for analysis on A&amp;E performance and community process and capacity. Supported by leadership through the SRG the data allows system pressures to be identified and response agreed in a timely manner.</td>
<td>May 2016</td>
</tr>
<tr>
<td>Capacity flow within the Acute has been identified as a key focus to allow patients to be cared for in the right setting. The MEDWORX complex weekly meeting agrees key deliverables for improving flow and capacity. The work streams include legal aspects of discharge; DTOC; utilization of community hospitals; in reach service and utilization of discharge to assess models including new step down beds.</td>
<td>July 2016</td>
</tr>
<tr>
<td>HIG workgroup links directly into the SRG work stream and focuses on the improvements in systems across all providers. The current work streams include acute to community flow, carers, transport, equipment and identification of complex delays</td>
<td>July 2016</td>
</tr>
<tr>
<td>Agreed within the Surrey work stream for SECAM contract GWCCG are working closely with SECAM to improve handover and 75% response times. The handover audit tool is used as the</td>
<td>Commences April 2016</td>
</tr>
<tr>
<td>Critical Milestone</td>
<td>Date</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
</tr>
<tr>
<td>baseline to indicate the current flow issues and the utilization of HALO have identified opportunities to jointly improve patient flow and experience. Potential work streams include utilizing the skill set of a paramedic within the handover area, redesign of the ambulance bay area within A&amp;E, advanced planning for patients with high volume use and utilization of PACE models across other service users.</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: A&E Recovery Plan

6.5.9 Improving care for patients in care homes by commissioning targeted support to community care homes, focusing on medication reviews, end of life care planning and treating, where appropriate, patients outside of acute care settings. The CCG continues to focus on delivering care closer to home and is working with partners to develop a whole system population based service model. “My Care, My Choice” integrated strategic partnership ensures that the unplanned care schemes are tailored towards building resilience into the system to ensure that the population continues to receive appropriate care, in the right setting, irrespective of changing demographics.

6.5.10 By developing services that are designed to support patients back into the community, when clinically indicated, supported by a robust needs-based care package, we aspire to reduce the demand on the A&E department, and in turn reduce the time that patients will have to wait for urgent care services. Additionally, the CCG will continue to develop outwardly facing communications that will help to support the community to make better choices about how they choose to access health care services. This will empower our residents to manage their own health, and make the right choices about accessing urgent care services when it is appropriate to do so.

6.5.11 The CCG will build upon existing relationships with the ambulance service provider to improve ambulance performance and ensure that urgent response times for patients meet the national targets. By continuing to promote the NHS 111 service, and commissioning a more comprehensive service model for NHS 111, this should help to reduce the demand on 999 urgent care responses, and in turn improve ambulance services performance. Additionally, by continuing to invest in integrated community care, and in supporting care homes more proactively, there should be a significant impact upon 999 activity levels.
6.5.12 The recently implemented ‘immediate handover policy’ between ambulance and A&E colleagues should significantly reduce the ambulance handover times being experienced in the Trust, with more resource available to respond to urgent care 999 demand.

6.5.13 With regards to mental health, the CCG will continue to support those patients experiencing a crisis in their mental health by extending the psychiatric liaison service to a 24/7 model. This will ensure a rapid response, irrespective of time of presentation, for those vulnerable individuals requiring dedicated mental health input and will ensure that they receive the care they need in the most appropriate care environment.

6.5.14 We will work with all stakeholders across the system to ensure that the needs of people with mental illness in crisis are responded to in line with people with physical health needs. We have developed a 24/7 Psychiatric Liaison Service at RSCH that ensures patients with mental illness, attending A&E or admitted, receive the physical and mental healthcare that meets their needs. We will continue to review and develop the pathways of care and support frequent attenders to the hospital through providing access to statutory and voluntary health and care support services, making reasonable adjustments as required.

6.5.15 To support the system to achieve the performance targets we have:

- Built upon the cross-system relationships through strengthening the System Resilience Group
- Commissioned and actively promoted a comprehensive service model for NHS 111
- Commissioned a Hospital Ambulance Liaison Officer system to reduce wasted ambulance handover time

6.6 We will continue to improve the system through implementation of the following milestones:

<table>
<thead>
<tr>
<th>Critical Milestones</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invest in integrated community care, and support care homes, through developing a locally commissioned care home service</td>
<td>September 2016</td>
</tr>
<tr>
<td>Critical Milestones</td>
<td>Timescale</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Performance manage the South East Coast Ambulance immediate handover policy to</td>
<td>April 2016</td>
</tr>
<tr>
<td>ensure that ambulance handover times are being reduced</td>
<td></td>
</tr>
<tr>
<td>Support patients who have mental health crisis through the provision of the Safe</td>
<td>June 2016</td>
</tr>
<tr>
<td>Haven Café in Guildford</td>
<td></td>
</tr>
<tr>
<td>Redesign of the 24/7 psychiatric liaison service, where CPNs are based in A&amp;E and</td>
<td>September 2016</td>
</tr>
<tr>
<td>included as part of the A&amp;E staffing establishment</td>
<td></td>
</tr>
<tr>
<td>Completion and ratification of a Falls strategy</td>
<td>June 2016</td>
</tr>
<tr>
<td>Commission new whole system Falls pathway</td>
<td>September 2016</td>
</tr>
<tr>
<td>Surrey wide stroke service commissioned</td>
<td>September 2016</td>
</tr>
<tr>
<td>Diabetes prevention plan – first wave</td>
<td>Commences April 2016</td>
</tr>
</tbody>
</table>

Table 9: Unplanned Care Programme Critical Milestones and deadlines

6.7 For all projects and schemes relating to unplanned care, quality and equality impact assessments will be performed as part of the standardised project management methodology. Where impacts are identified either by project leads or the quality team, mitigating actions will be planned, and there will be close integration with the CCG risk register. Quality surveillance will then be a core component to ensure the realisation of benefit.
7 NHS Constitution Standards

Meeting the NHS Constitution Standards

7.2 The CCG are undertaking a wide range of specific actions to improve performance against NHS Constitution standards are detailed in sections 5 (Access standards and A&E) and 8 (Cancer), of this plan. Actions to attain the Referral to Treatment (RTT) standard of 92% of patients on non-emergency pathways will wait no more than 18 weeks, including offering patient choice are described below.

Chart 4: Incomplete pathways Royal Surrey County Hospital (for all) – snapshot March 2016

7.3 The CCG have established robust performance management tools that enable us to update and review RSCH position at specialty level. This has provided a level a granularity that enables the CCG to address specific specialities.

Chart 5: Breach analysis for (All) incomplete pathways at Royal Surrey County Hospital
7.4 The RSCH have reviewed and confirmed that they are applying the rules in line with their peers. The CCG continued to work jointly with the RSCH and NHS IMAS to agree an action plan to address accurately reporting activity under the RTT pathways. This work has now been completed.

7.5 Senior representation from the CCG and RSCH at the weekly 18 Weeks Working Group and the monthly 18 Weeks Assurance Meeting, to monitor delivery, is indicative of the joint approach and effort to address sub optimal performance. The escalation route for performance concerns is through the monthly formal contract management meetings.

7.6 Due to under-performance in diagnostic waiting times (within 6 weeks), the CCG seeks assurance from RSCH that all Cancer and urgent patients are being booked within the required timeframes. In addition the capacity planning project is being implemented for Endoscopy using the IMAS recommended tool.

7.7 Urology RTT performance presents a continuing concern, with further adverse performance likely as the backlog is cleared. A whole scale redesign project is underway regarding Urology, which the CCG is party to.

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>29-Feb</th>
<th>21-Mar</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>92.9%</td>
<td>92.04%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>84.8%</td>
<td>83.7%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>87.0%</td>
<td>85.3%</td>
<td>-1.7%</td>
</tr>
<tr>
<td>CARDIOLOGY</td>
<td>90.1%</td>
<td>88.0%</td>
<td>-2.1%</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>90.1%</td>
<td>89.9%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>GENERAL SURGERY</td>
<td>91.3%</td>
<td>89.9%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>89.6%</td>
<td>90.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>92.8%</td>
<td>90.2%</td>
<td>-2.6%</td>
</tr>
<tr>
<td>GERIATRIC MEDICINE</td>
<td>96.0%</td>
<td>91.2%</td>
<td>-4.8%</td>
</tr>
<tr>
<td>GYNAECOLOGY</td>
<td>92.5%</td>
<td>91.6%</td>
<td>-0.9%</td>
</tr>
</tbody>
</table>

Table 10: Snap shot position of incompletes and will change on a daily basis
8 Cancer

8.2 Local context:

- The prevalence of all cancers in Surrey is higher than that for England.
- Most cancers, when compared nationally, have a higher one and five year survival rate with the exception of prostate one year survival.
- Mortality rates from colorectal/bowel cancer in Surrey is higher than England.
- Mortality rates for cervical cancer in Surrey is lower than England.
- Gynaecological cancers rank the 5th most common in Surrey.
- Breast Cancer is the most common cancer in the UK, this is also true for Surrey with an incidence of 893 in 2008.
- Lung cancer is the 2nd most common cancer in the UK but the 4th most common in Surrey.
- There is a lack of information of the impact of childhood cancers in Surrey.

This section sets out the CCG actions that are required for the whole health economy to achieve the cancer standards set out in the NHS Constitution, focussing on the following areas:

- Two week cancer waiting standard;
- 31 day cancer waiting standard;
- 62 day cancer waiting standard;
- Improving access to diagnostic services;
- Improving one-year survival rates;
- Reducing the proportion of cancers diagnosed following an emergency admission.

8.3 These areas of focus are underpinned by the CCG’s overarching vision for cancer which 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 through 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

8.4 In July 2015, an Independent Cancer Taskforce produced a 5 year Cancer Strategy entitled ‘Achieving World Class Cancer Outcomes – A Strategy for England’ which detailed 96 recommendations which should impact significantly on the overall improvement to national cancer outcomes. It outlines how an additional 30,000 patients every year could survive cancer for 10 years or more by 2020; around 11,000 through earlier diagnosis.

8.5 The six priorities in ‘Achieving World Class Cancer Outcomes – A Strategy for England’ are detailed below:

8.6 An implementation plan is expected from NHS England in early 2016, which will provide direction on how services should be commissioned, and the timescales to be achieved.
Two week referral

8.7 The CCG and the RSCH have agreed and approved a remedial action plan to improve Cancer Waiting Times which is linked with the Monitor action plan. Representatives from the CCG attend the weekly Cancer Patient Tracking List (PTL) meeting and performance has been improving week on week. The 2 week wait exhibited Non-Cancer Breast Symptoms standard continues to be a challenge, however patient choice is the issue with a significant majority choosing not to attend within 2 weeks. Work is being undertaken with practices to ensure patients understand the need to attend within this timeframe.

Cancer waiting standards

8.8 The CCG is currently compliant with the 31 day cancer waiting standards and performance against the 62 day waiting standard is currently delivering within the national expectations. However, performance by the provider of the CCGs main contract, Royal Surrey County Hospital, remains below expected levels and has been throughout 15/16. A formal contract notice was issued to RSCH in November 2015.

8.9 In response to this the CCG established a quarterly meeting with RSCH, NHS England and Cancer Network to jointly understand the underlying causes of the performance issues and agree plans for improvement. The Trust has agreed with the CCG and Monitor a remedial action plan to ensure performance is both returned to expected levels and sustained. This is supported by CCG involvement in the trust weekly cancer patient tracking list meeting where appropriate challenge and support is provided. This involvement has been commended by NHS IMAS, who have also provided support to the Trust to ensure this key performance target is delivered.

8.10 Since the end of the 2015 there has been a largely consistent improvement in performance, with the trust on target to deliver their recovery trajectory by April 2016.

8.11 Urology has been under significant pressure and has seen the slowest level of recovery. Further challenge has been applied to the Trust and a delivery plan for this speciality has now been agreed. This will see a drop in performance at the end of the 2015/16 financial year. However this will clear the backlog of patients and will enable the trust to start the 2016/17 financial year in a good position.
8.12 The systems and processes implemented in 2015/16 will be continued at least into the first half of 2016/17 to ensure that performance is maintained and the trust is in a position to ensure sustainable delivery.

**Improving access to Diagnostic Services**

8.13 Around half of our population will be diagnosed with cancer in their lifetimes. This high incidence creates pressures across the pathway – from seeing a specialist, to receiving a test, to receiving results, and ultimately commencing treatment. Rising demand for diagnostic tests, and the resulting pressure on services, means action is now needed. Ensuring diagnostic capacity to meet future demand will be essential to improve cancer outcomes through early diagnosis. When cancer is diagnosed at an early stage, treatment options and chances of a full recovery are greater.

8.14 NICE guidance: ‘Suspected cancer: recognition and referral’ issued in June 2015, relies mainly on evidence derived from primary, rather than secondary, care and it assumes that patients have had a full history, clinical examination and appropriate blood tests. The threshold for referrals has been lowered from a PPV (positive predictive value) of 5% to 3%. This is even lower in some circumstances such as childhood cancers. There are particular implications for diagnostics with the expectation of an expanded range of direct access tests for primary care.

**Imaging**

8.15 There are a number of challenges facing medical imaging services. National information suggests that:

- Imaging activity has been growing at nearly 6% per annum over the last ten years;
- In future, demand for MRI and CT is likely to grow at 9% per annum or more;
- There is a lack of capacity to respond to this increasing demand;
- Some funding models can inhibit meeting future demand

8.16 Despite the challenges, the RSCH imaging departments continue to provide a good imaging service for (identified and suspected) cancer patients. The RSCH imaging department will prioritise the inpatient/emergency patient pathway and the cancer pathway above all other pathways. If the RSCH
imaging department is under pressure to meet demand, the risk is that planned care and community-based patients will have to wait longer than six weeks for image acquisition and a report.

8.17 We have set an ambition that by 2020, 95% of patients referred for testing by a GP are either definitively diagnosed with cancer, or cancer is excluded, and that the result will be communicated to the patient, within four weeks.

8.18 We will examine available solutions which may include ‘out of hospital diagnostic centres’, or multi-disciplinary diagnostic centres, that are able to offer separate services for planned and community care.

Endoscopy

8.19 Endoscopy plays a vital role in the diagnosis of, and on-going surveillance for, gastrointestinal cancers, including bowel and oesophageal cancer. Endoscopy is also performed for the diagnosis, surveillance and treatment of a wide range of conditions and diseases that are not cancer-related.

8.20 Nationally, expected demand for lower gastrointestinal endoscopies i.e. colonoscopy and flexible sigmoidoscopy is projected to be double that of 2012.

8.21 Whilst we recognise that there is a considerable gap between current capacity and demand for endoscopy services, we will need to work collaboratively to implement the recommendations of Achieving World-Class Cancer Outcomes.

8.22 Nationally, more than 750,000 additional endoscopy procedures a year will be undertaken by 2020 – this is more than the population of Leeds - and represents a 44 per cent increase on current activity.

8.23 Some aspects of the recommendations, particularly those relating to diagnostics, require a change to current commissioning arrangements, so that necessary services are in place to enable GPs to follow the new guidelines. The CCG is working with RSCH to ensure a co-ordinated and timely approach to providing capacity within current services, and access to additional services where those are not currently in place. Essentially the key actions that we will deliver in partnership with providers through 2016/17 are as follows:
Critical Milestones | Timescale
---|---
G&W Cancer Improvement Plan will place patients at the centre of their care. | April 2016
Support RSCH to develop a workforce programme that enables them to meet the change in demand. | June 2016
Clear, funded development plans that approach the delivery of diagnostics in new and innovative ways will deliver the capacity for the predicted increase in demand | September 2016
Develop innovative ways to meet rising demand for endoscopy. | September 2016
Explore ‘out of hospital diagnostic centres’, or multi-disciplinary diagnostic centres, that are able to offer separate services for planned and community care. | March 2017

Table 11: Cancer Improvement Critical Milestones and deadlines

**Improving one-year survival rates**

8.24 Cancer diagnosed at an early stage is more likely to be treated successfully. If the cancer has spread, treatment becomes more difficult, and generally the chances of survival are much lower.

8.25 Below are some examples of how identifying cancer early can make a real difference:

- **Bowel cancer** - More than 9 in 10 bowel cancer patients will survive the disease for more than 5 years if diagnosed at the earliest stage\(^2\);

- **Breast cancer** - More than 90% of women diagnosed with breast cancer at the earliest stage survive their disease for at least 5 years compared, to around 15% for women diagnosed with the most advanced stage of disease\(^3\);

- **Ovarian cancer** - More than 90% of women diagnosed with the earliest stage ovarian cancer survive their disease for at least 5 years, compared to around 5% for women diagnosed with the most advanced stage of disease\(^4\);

---

\(^2\) Cancer Research UK. Bowel cancer survival statistics. 2015  
\(^3\) Cancer Research UK. Breast cancer survival statistics. 2015  
\(^4\) Cancer Research UK. Ovarian cancer survival statistics. 2015
• **Lung cancer** - Around 70% of lung cancer patients will survive for at least a year if diagnosed at the earliest stage, compared to around 14% for people diagnosed with the most advanced stage of disease\(^5\);

8.26 Improving survival rates is not just down to earlier diagnosis – ensuring patients receive the most effective and appropriate treatment for them is also an important part of the jigsaw.

8.27 There are many possible causes of late diagnosis. Around 1 in 4 cancers in the UK are diagnosed through emergency admission to hospital. Most patients diagnosed in this way have lower chances of survival compared to other patients.

8.28 There can be a number of reasons for delays in cancer diagnosis, for example:

- Low awareness of cancer signs and symptoms can mean that people don’t see the GP as soon as they might;
- People worry about what the doctor might find or don’t want to waste the doctor’s time;
- GPs referring patients on for tests, or treatment may be delayed;
- Access to hospital appointments

8.29 We are working with Public Health England and the local Surrey Health and Wellbeing Board to ensure that the national cancer awareness campaign is implemented locally to improve the public awareness of the signs and symptoms of cancer. Surrey Public Health team are targeting work on prevention of cancer e.g. stop smoking initiatives, and increasing awareness of the signs and symptoms of cancer e.g. working with schools on appropriate lesson plans. The local Prevention Plan is being reviewed and will be refreshed taking into account the priorities set out in the operational plan guidance. A comprehensive Prevention Project Plan will be developed to detail areas where we can collectively make a positive impact.

8.30 We will work with partners to implement the introduction of new referral proforma templates, initially produced by the Merseyside and Cheshire Cancer Network, and adopted by Cancer Research UK. However, they require robust primary care engagement, and are still to be reviewed and approved by the Royal College of General Practitioners (RCGP).

\(^5\) Cancer Research UK. Ovarian lung survival statistics. 2015
8.31 Once approved by the RCGP, they will require discussion and approval locally. It is proposed that this happens through the cancer Tumour Specific Site Groups, with final sign off at St Luke’s Cancer Alliance Steering Group. It is recognised that some new pathways will be easier to implement as the proposed changes have limited impact, whilst there are wider implications for other areas such as upper gastrointestinal.

8.32 The review of available pathways and direct access diagnostics indicates that most of the tests identified in the guidance are already provided by direct access. The direct access tests not currently provided at RSCH are:

- CT (for pancreatic tumour site);
- MRI (for brain and nervous system tumour site);
- Endoscopy (for oesophageal and stomach tumour site).

8.33 We are working with the RSCH to implement a pilot that will test proof of concept and inform the specification for direct access diagnostics. This will enable the CCG to commission the diagnostic provision required to meet NICE guidelines.

8.34 Cancer survival rates in England have never been higher, but we know that we are behind the highest performing countries in the world in international comparisons. We also know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. The independent cancer taskforce, in their report Achieving World-Class Cancer Outcomes, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will require every CCG to focus on and make significant improvement in early stage diagnoses.

8.35 The national quality premiums include a premium for achieving improvement in the early diagnosis of cancer. There is the option to either demonstrate a 4% point improvement in the proportion of cancers diagnosed at stages 1 and 2 or achieve greater than 60% of all cancers diagnosed at stages 1 and 2. The CCG has selected to work towards the former option.

8.36 In addition to this Cancer has been identified as a key area for review and improvement across the STP footprint. Guildford and Waverley CCG are leading this work stream and will establish a co-produced strategy and a clear and deliverable work plan across the 3 CCGs during 2016.
Living well and beyond

8.37 The CCG is working with neighbouring CCGS to establish how we meet the commissioner guidelines for service provision as set out in the ‘Recovery Package’. This will be a combination of different interventions which, when delivered together, will greatly improve the outcomes and coordination of care for people living with and beyond cancer. These are:

- Holistic Needs Assessments and care planning at key points of the care pathway;
- A Treatment Summary completed at the end of each acute treatment phase, sent to patient and GP;
- A Cancer Care Review completed by GP or practice nurse to discuss the person’s needs;
- A patient education and support event, such as a Health and Wellbeing Clinic, to prepare the person for the transition to supported self-management, which will include advice on healthy lifestyle and physical activity.

Reducing the proportion of cancers diagnosed following an emergency admission.

8.38 We need to explore why opportunities to diagnose and treat patients at the earliest opportunity are missed. A quarter of cancer patients are currently diagnosed following an emergency admission to hospital and go on to have poorer outcomes than those who are diagnosed during an earlier stage of their illness.

8.39 Understanding the reasons behind late diagnosis, and also achieving a better understanding of the management of patients diagnosed following an emergency admission, will improve the evidence base for the development of acute oncology services.
9 Mental Health Services

9.2 It is within the national context, as set out in the NHS Forward View, that Guildford & Waverley CCG has set out how it will fulfil the standard of mental health care that our local population should receive now and in the foreseeable future.

9.3 The CCG will establish a Mental Health programme that will have the following priorities in 2016/17:

- Achieve and maintain the **two new mental health access standards**
  - more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;
  - 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95% treated within 18 weeks;
- Meet the **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

9.4 We regard Mental Health as being as important as physical health and we will seek to transform lives by making mental health everybody’s business with parity of esteem to physical health. We will work together to build a place where people feel proud and safe to live and where people with mental health problems, their families and carers’ needs and basic rights are met, recognised and respected.

9.5 We will address the priorities set out in the Surrey Health & Wellbeing Board Strategic Plan, in order to achieve localised solutions. We will develop a Guildford and Waverley Mental Health Strategic Delivery plan that will enable us to review the local requirements and set in place a series of service improvements to achieve high quality, easily accessible mental health services for our local population. This will provide a clear strategic approach to promoting and improving mental health, as demonstrated by on-going work around early dementia diagnosis within our 21 GP Practices and local care homes.

9.6 This section sets out the GWCCG priorities for 2016/17, specific actions have been taken to date and our plans to deliver against the following priority domains:
- Domain 2- Improving Health
- Domain 4- Parity of Esteem for Mental Health
- Domain 5- Convenient Access for Everyone
- Domain 6- Meeting the NHS Constitution Standards

**Domain 2 - Improving Health:**

9.7 We work closely and collaboratively with our partners in Public Health and Surrey County Council to use public health data to inform and develop the local Joint Specific Needs Assessment (JSNA) report. This includes important data on local prevalence and morbidity around mental ill-health within the local community. GWCCG is an active participant in our local Health & Wellbeing Board where mental health commissioning and provision is a standing agenda item. GWCCG actively prioritises mental health promotion, and raising mental health awareness, among the local workforce through comprehensive training initiatives across primary care, acute hospitals and ambulance staff. We are working with all our GP Practices to support our priorities of early detection of mental ill health and the development of a clear pathway to appropriate treatment through Improving Access to Psychological Therapies (IAPT).

9.8 On-going work around early dementia diagnosis, with our 21 GP Practices and local care homes, also involves supporting our primary, secondary and third sector providers in delivering optimal post-diagnostic follow up care to ensure that both patients and, importantly, carers and families continue to live well post diagnosis. This is also demonstrated in our prioritisation of physical health checks for our patients diagnosed with learning disability.

**New Mental Health Standards**

9.9 The IAPT service is provided under the current Any Qualified Provider (AQP) contract with five individual providers delivering the service locally. The current AQP contract is not delivering the 15% KPI access to treatment target currently it is 12.9%. The reason for this low level of access is predominantly due to the responsiveness of the providers, due to workforce pressures. Working in an environment with multiple providers competing for a fairly static workforce. The CCG are exploring a variant model for the provision of IAPT and intend to commission a new service that is able to interface with both Primary and Secondary Mental health providers.
9.10 Self-referral mechanisms, brought about through undertaking equality analysis, improved our position year on year by 5% against the access to treatment target of 15%; it is expected that this improvement will continue into 2016/17. A mental health GP education event focusing on IAPT is planned for September 2016 with aim of raising awareness of services and increase referrals. The CCG are developing Surrey wide CQUINs for IAPT to improve access, particularly for older people, hearing impaired and medically unexplained symptoms.

9.11 The longer term plan to achieve the access to treatment target of 15% in 2016/17 and then the increased target in future years to 25% access rates, is to commission a single integrated provider model. This model will provide a more responsive, efficient and effective service which will deliver clinical benefits to our local population.

9.12 Key benefits of a single provider model are:
- Single Point of Entry;
- Single Assessment Process;
- Referrals for IAPT from Integrated Care Hubs;
- Supports Self-Referral;
- Clear navigation across the pathway to prevent people falling through the gaps;
- Aligned and integrated mental health system with KPIs and reporting;
- Reduce duplication and improve clinical efficiency for the people of Guildford and Waverley;
- Improved satisfaction and outcomes.

<table>
<thead>
<tr>
<th>Critical Milestones</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Mental Health Education Event with focus on IAPT to promote service and increase referrals</td>
<td>September 2016</td>
</tr>
<tr>
<td>Serve 12 months’ notice on current AQP IAPT contracts</td>
<td>1st October 2016</td>
</tr>
<tr>
<td>Commence procurement process</td>
<td>1st October 2016</td>
</tr>
<tr>
<td>Award contract to preferred bidder</td>
<td>1st April 2017</td>
</tr>
<tr>
<td>Mobilisation phase complete</td>
<td>31st September 2017</td>
</tr>
<tr>
<td>Single provider IAPT model ‘go live’</td>
<td>1st October 2017</td>
</tr>
</tbody>
</table>

Table 12: Improving IAPT critical milestones and deadlines
Domain 4 - Parity of Esteem:

9.13 IAPT services are commissioned to prioritise key groups in our local community who are likely to experience a higher incidence of co-existent physical & mental health problems, for example, those with long term physical health conditions (heart disease, diabetes), BME, veterans, those from travelling community who may not readily chose to access health/mental health services.

9.14 GWCCG is a full signatory to the Surrey Crisis Care Concordat, a multi-agency/multi-stakeholder agreement to respond to a mental health crisis in the community consistent with what individuals with emergency/acute physical health care needs would expect, that is, timely, patient centred, non-stigmatising health care in the most appropriate care environment.

9.15 The Psychiatric Liaison Service (PLS) at RSCH is a key part of how Parity of Esteem is realised locally. The service has been extended to ensure that patients within RSCH have timely access to a comprehensive psychiatric assessment and early treatment, where indicated. We prioritise this service as we know many patients present to A&E in psychiatric crisis, with or without physical health care needs. We also know that some patients, including typically elderly patients with physical health care needs, especially those with more chronic longer term conditions such as coronary heart disease or diabetes, are at much greater risk of either having or developing mental illness, such as clinical depression. As a result, we have now commissioned a 24/7 Psychiatric Liaison service to support the local mental health acute care pathway and comply with local and national policy imperatives around crisis care, Access & Waiting Time Standards and Parity of Esteem.

9.16 There is now a legal obligation for providers to offer choice in mental health care (as is the case for physical health care currently). GWCCG expects our providers to demonstrate this via the contractual Service Development Improvement Plans. We are working with our local GPs to inform them which services patients must have choice for.

Domain 5- Convenient Access for everyone:

9.17 We are committed to working with our providers to ensure that, as of April 2016, patients will have timely access to required mental health care in line with the NHSE directive on access and waiting times standards. Key mental health services where this is particularly relevant are “Early Intervention in
Psychosis”, Adult IAPT, Liaison Psychiatry and the Children & Young People’s Eating Disorder Service. GWCCG will commission services that uphold the new Waiting Times standards of 75% of people referred for psychological therapies receiving treatment within 6 weeks, and 95% within 18 weeks.

9.18 We will continue to work with our main NHS mental health provider to further develop an acute mental health care pathway which offers choice, where indicated, to our patients in this area. For example, a key development will be the establishment of a “Safe Haven” community Crisis service in the Guildford and Waverley locality as an alternative to acute hospital admission or other secondary care mental health service involvement.

Domain 6 - Meeting the NHS Constitution Standards:

9.19 The CCG works closely with NE Hampshire & Farnham CCG to ensure robust contract monitoring of the full range of mental health services currently commissioned for our local population. To achieve the NHS Constitution Standards, we will:

<table>
<thead>
<tr>
<th>Mental Health Programme Key Deliverables:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Develop a five-year training programme</td>
<td>September 2016</td>
</tr>
<tr>
<td>aimed at clinicians, front line staff,</td>
<td></td>
</tr>
<tr>
<td>community and third sector and others to</td>
<td></td>
</tr>
<tr>
<td>support and skills in responding to, and</td>
<td></td>
</tr>
<tr>
<td>signposting to services for mental</td>
<td></td>
</tr>
<tr>
<td>health problems including suicide risk</td>
<td></td>
</tr>
<tr>
<td>and increased high risk alcohol use.</td>
<td></td>
</tr>
<tr>
<td>2 Develop a dedicated mental health</td>
<td>December 2016</td>
</tr>
<tr>
<td>system mapping website</td>
<td></td>
</tr>
<tr>
<td>3 Commission a primary care/community</td>
<td>December 2016</td>
</tr>
<tr>
<td>based social prescribing model designed</td>
<td></td>
</tr>
<tr>
<td>to support people with mental health</td>
<td></td>
</tr>
<tr>
<td>issues at an early stage in order to</td>
<td></td>
</tr>
<tr>
<td>prevent deterioration and need for</td>
<td></td>
</tr>
<tr>
<td>specialist and crises services.</td>
<td></td>
</tr>
<tr>
<td>4 Commission a walk in mental health</td>
<td>June 2016</td>
</tr>
<tr>
<td>crisis service reducing the number of</td>
<td></td>
</tr>
<tr>
<td>mental health service users accessing</td>
<td></td>
</tr>
<tr>
<td>primary care and A &amp; E and improve</td>
<td></td>
</tr>
<tr>
<td>service users’ experience of care and</td>
<td></td>
</tr>
<tr>
<td>support.</td>
<td></td>
</tr>
<tr>
<td>5 Redesign commissioned services to offer</td>
<td>September 2016</td>
</tr>
<tr>
<td>‘in reach’ support to GPs.</td>
<td></td>
</tr>
<tr>
<td>6 Introduce personal health budgets for</td>
<td>June 2016</td>
</tr>
<tr>
<td>a targeted population as a project to</td>
<td></td>
</tr>
<tr>
<td>monitor the impact on service users’</td>
<td></td>
</tr>
<tr>
<td>health and wellbeing and the use of NHS</td>
<td></td>
</tr>
<tr>
<td>services.</td>
<td></td>
</tr>
</tbody>
</table>

Table 13: Mental Health critical milestones and deadlines
Young Adult access to Mental Health service

9.20 We will consider how the new Child and Adolescent Mental Health Service (CAMHS) will be able to support access to age appropriate mental health services for young people under the age of 25 across Guildford and Waverley, in particular how young people are transferred in a supportive and coordinated way from the CAMHS to the adult mental health pathway. We need to analyse and understand the impact on Surrey and Borders Partnership Trust and how we reconfigure adult services to ensure community and crisis care is maintained. Our CAMHS Transformation Plans will drive forward innovation; further improving access, reducing stigma and ensuring prompt, effective support, including in times of crisis.

Reducing the life expectancy gap for patients with mental health illness

9.21 We will target in-patients who we know are most at risk, and where major opportunities exist to increase knowledge about healthy lifestyles and support smoking cessation.

9.22 Mental Health developments will promote communication between the mental health services and the patients’ GP and practice nurse who continue to be responsible for the physical health care post discharge. This collaboration is key to sustainability as care after discharge is as important as care on the ward.

Development of a crisis response service

9.23 We will work with all stakeholders across the system to ensure that the needs of people with mental illness in crisis are responded to in line with people with physical health needs. We have developed a 24/7 Psychiatric Liaison Service at RSCH that ensures patients with mental illness, attending A&E or admitted, receive the physical and mental healthcare that meets their needs. We will continue to review and develop the pathways of care and support frequent attenders to the hospital through providing access to statutory and voluntary health and care support services, making reasonable adjustments as required.

Dementia

9.24 During 2015/16 we have increased the Dementia diagnosis rate from 44% to just under 60%. We recognise that there is more to do; we have identified
resources to deliver additional services into Care Homes and Primary Care in order to improve the early identification of dementia.

9.25 In 2016/17 we will continue to develop a Guildford and Waverley Dementia Strategy Delivery Plan that will set out clear objectives and establish the clear timescales and milestones required to implement the ambitions set out in the Surrey wide Dementia Strategy.

9.26 We want to create a universal, consistent offer, including:

- Developing carer support services to reduce geographical inequalities in access to services
- Increasing rates of timely diagnosis
- Developing a clear pathway for patients diagnosed with dementia
- Training professional dementia carers to recognise and act on signs of deterioration
- Developing services to support frail elderly patients in residential care
- Creating 'dementia friendly hospitals' and communities

### Dementia Programme Key Deliverables

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and redesign existing care pathways to fit the new service design</td>
<td>September 2016</td>
</tr>
<tr>
<td>Support primary care in early diagnosis</td>
<td>December 2016</td>
</tr>
<tr>
<td>Ensure there are appropriate services in place to support people with early onset dementia and their carers</td>
<td>July 2016</td>
</tr>
<tr>
<td>Ensure staff and carers have the training to address the needs of people with dementia and mental illness</td>
<td>July 2016</td>
</tr>
<tr>
<td>Ensure carers can access training to address the needs of people with dementia and mental illness</td>
<td>September 2016</td>
</tr>
<tr>
<td>Increase access to support and advice for carers of people with dementia or older people with mental health problems</td>
<td>July 2016</td>
</tr>
</tbody>
</table>

Table 14: Dementia improvement critical milestones and deadlines
10 Transforming care for people with learning disabilities

10.2 We are cognisant of the challenge facing us to ensure the needs of people with a Learning Disability, their families and carers are met. The local health and care system is jointly committed to transform care for people with learning disabilities and/or autism. Our shared vision and commitment is set out in the Surrey Learning Disability Partnership strategy for people with a learning disability and/or autism 2016 to 2020. We work across the Surrey footprint to ensure that we continue to improve the outcomes for people with a learning disability, their families and carers.

10.3 People with learning disabilities and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives. They should have a place to live and be involved in the design and delivery of the support they receive. Our joint strategic goals are to help people stay healthy, live their life and keep safe.

Figure 8: Surrey Learning Disability Partnership Vision

10.4 The strategic goals set out in the Surrey Learning Disability Strategy are:
**Staying Healthy** - Individuals have the right support that enables them to stay well and receive the right care and treatment they need.

10.5 To support this goal we will:
- Ensure that people are informed, supported and have access to annual health checks, screening and health promotion.
- Ensure that everyone has access to good quality health services, which make reasonable adjustments to meet their needs.
- Develop joined up health and social care providing seamless care and support.
- Provide local responsive alternatives to admission to hospital.
- Develop a skilled workforce to meet needs when individuals have complex needs.

**Living My Life** - Individuals have a great start to life and are supported to live and age well, having opportunities to contribute to their local community.

10.6 To support this goal we will:
- Ensure people are supported to participate in purposeful activity including education, training, and employment and volunteering.
- Ensure carers have their needs identified and met to help maintain their caring role.
- Promote the use of personal budgets and health budgets to develop opportunities. Work with District and Boroughs to promote inclusion in local communities.
- Develop housing options with providers and the NHS through co-design.
- Plan with providers for an appropriate skilled workforce.

**Keeping Safe** - Individuals supported in both Surrey and out of county will experience quality services that are responsive to individuals’ needs, keeping them safe, delivering value for money.

10.7 To support this goal we will:
- Work with friends, families and communities to prevent isolation and promote inclusive lives.
- Ensure the community is educated to help stop discrimination and prejudice.
- Ensure people have access to the right information, advice and advocacy to make informed choices about the support they need.
- Ensure people are cared for and safeguarded in their local community.
- Work with the Police and Criminal Justice.
# Learning Disabilities Programme Key Deliverables

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop a Learning Disability Strategy Delivery plan for Guildford and Waverley</td>
<td>June 2016</td>
</tr>
<tr>
<td>2. Establish the Personal Budget arrangements for people with Learning Disability</td>
<td>June 2016</td>
</tr>
</tbody>
</table>

Table 15: Learning Disabilities improvement critical milestones and deadlines
11 Research and Innovation

11.2 GWCCG discharge their statutory obligation to promote and support research to improve the quality of healthcare services into the future in a number of ways, which includes the Primary Care Clinical Academic Group (PCCAG) established in January 2015, in partnership with Surrey University and under the auspices of Surrey Health Partners (SHP).

11.3 A member of the GWCCG Governing Body co-chairs the PCCAG alongside a senior GP Partner and Professor at Surrey University. The CAG is one of ten which are supported by SHP and wherever relevant, opportunities are taken to promote collaboration between the various areas of clinical research and primary care represented amongst the research groups.

11.4 The CAG has evolved from the Clinical Research Forum established by GWCCG and has attracted funding from SHP to promote and enhance the work of the group. Membership of the CAG continues to grow and we are looking to involve member practices where feasible. Research governance principles are incorporated within the Terms of Reference for the CAG and outcomes of the group are reported to the Quality and Clinical Governance Committee of the CCG which receives the minutes of the CAG. In addition, reports are made regularly to the SHP steering group.

11.5 In recognition of the requirements of the Operational and the Sustainability & Transformation Plans, and to sustain the evolution of the CAG, the CAG held its first strategy seminar on 1 December 2015. This involved a range of stakeholders, including patient representatives, and provided an opportunity to collaborate in setting a strategic framework to facilitate the future programme of research.

11.6 A range of funded projects are in progress, including ‘GHT 2000’ which is evaluating the outcomes of promoting healthy life choices for patients with raised blood pressure -including exercise -and assessing the impact of this on the prevention of ill health that would otherwise require long term medication. This has recruited well from member practices and is one of the largest studies of its kind currently underway.

11.7 The Surrey Health Partners Development & Innovations Fund has been created to support Clinical Academic Groups to forge closer collaboration through networking and infrastructure development, and to support the
intellectual advancement and practical delivery of new and pioneering research and educational proposals. This has enabled Surrey to become an international centre of health and medical research and educational excellence and service improvement leadership.

11.8 A joint award has been made to the Primary Care CAG in collaboration with the Diabetes CAG to develop a Surrey Cohort which will be a repository holding computerised health data, and links to patient data for the Surrey population. Its purpose will be to support a better understanding of our community’s health, research and quality improvement programmes. Once implemented, the database will facilitate local health service management and attract researchers and research funding across the partnership. This is an innovative project with the potential to impact patient care and to realise economic benefits through more streamlined recruitment of patients to research trials, which has proved a costly local challenge. The evaluation panel was delighted to receive an application that was a truly collaborative effort developed by the Primary Care CAG and Diabetes CAG, with written support from the Mental Health CAG, Surrey Cancer Research Institute and the Chief Executive of GWCCG.

11.9 Other projects being explored include an audiology study, a friends and family pilot test in primary practice, managing renal anaemia in primary care, evaluating impact of different education programmes around alcohol awareness (with public health) and various potential projects around end of life care.

11.10 Another ambition for the CAG is to hold a varied programme of educational events each year. In this way research outcomes and their relevance to primary practice will be shared amongst the membership of the CCG and other supporting partners in the health economy. The commissioning plan takes account of the research outcomes to inform service redesign.

11.11 The Surrey Transformation Board, which is chaired by our CCG Chair, will include representatives from the Academic Health Science Network. 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.

11.12 As part of Surrey Clinical Commissioning Group’s 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 to support a transformational programme around Stroke and cardiovascular diseases in Surrey. This bid is designed to create a healthcare environment that will be fit for purpose with Keogh’s vision for Transforming Urgent and Emergency Services.

11.13 Through the Surrey Clinical Commissioning Group’s Collaborative, we will expand our existing 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.

11.14 Progress with research projects and the research programme will form part of the Quality and Governance Committee’s work plan. The remit will include triangulation of any risks or issues concerning quality to ensure that future topics focus on the improvement of healthcare services.
12 Improvements in Quality

12.1 To achieve the vision, GWCCG has the following seven strategic quality goals to:
- Possess robust quality information;
- Report and monitor quality information;
- Prevent sub-optimal quality;
- Establish expectations of quality;
- Reward quality;
- Work collaboratively to achieve system wide quality improvements;
- Determine the success of the quality strategy.

12.2 These goals are the essential key steps for robust quality assurance and improvement. Their success will be based on the successful implementation of a number of key actions that are priorities for 2016/17. These include actions such as the further development of the quality dashboard; Improvement in public, patient and General Practitioner feedback on the quality of services and improved methods of identifying quality goals that are incentivized through various payment schemes.

12.3 GWCCG recognises that the quality strategy is ambitious, but are determined to achieve success in collaboration with the provider organisations we are commission services from. Success is ultimately the experience, outcomes and benefits for patients, their families and carers gain and will ensure that our statutory obligations for quality are fulfilled.

12.4 Winterbourne View/Transforming Care

12.4.1 Transforming care is one of NHS England’s four national clinical priorities and during 2015-16 significant progress has been made nationally in reducing length of stay for learning disability inpatients. However, efforts need to continue to ensure this progress does not slow down.

12.4.2 NHS England has identified seven commissioning standards for Transforming Care for CCGs. These seven standards will underpin GWCCG’s commitment to the Transforming Care agenda, ensuring optimal outcomes for patients with learning disabilities. A Learning Disability Strategy Delivery Plan will be our vehicle that will identify the areas where we can improve and what we need to do to achieve this. Responding to the imperative to achieve this across the whole system, we will establish a local multi-agency working group and engage with service users, their families
and carers to develop the plan, review and assess progress against the following seven standards:

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realistic discharge date, agreed at a Care Programme Approach (CPA) or Care and Treatment Review (CTR) meeting</td>
<td>May 2016</td>
</tr>
<tr>
<td>Care and Treatment Reviews in line with national guidance, and chaired by the CCG.</td>
<td>April 2016</td>
</tr>
<tr>
<td>Pre-admission (community) CTRs</td>
<td>April 2016</td>
</tr>
<tr>
<td>Care manager delivering active case management and discharge planning</td>
<td>April 2016</td>
</tr>
<tr>
<td>The CCG and Local Authority will work collaboratively to:</td>
<td></td>
</tr>
<tr>
<td>Identify individuals at risk of admission to inpatient services</td>
<td>June 2016</td>
</tr>
<tr>
<td>Assess progress for at least six months post discharge.</td>
<td>October 2016</td>
</tr>
<tr>
<td>Hold the provider to account for delivery of the recommendations made in patients’ CTRs or CPA reviews.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Be assured that community multi-disciplinary learning disabilities professionals are in place that can respond rapidly to implement or strengthen community placements</td>
<td>April 2016</td>
</tr>
</tbody>
</table>

Table 16: Learning Disabilities Transformation Care critical milestones and deadlines

12.5 Personal Health Budgets

Personal health budgets (PHB)

12.5.1 The Personalisation agenda is central to the development of a local Guildford & Waverley Personal Health Budget offer. Within Guildford & Waverley there is an existing PHB offer in place to those individuals who meet the threshold for Continuing Healthcare funding. On 1st April 2016 NHS England mandated that a PHB be considered for children and adults with a long term health condition with initial focus on children’s educational need through an Education, Health and Care Plan, and both children and adults with a learning disability or mental health condition.

12.5.2 G&WCCG will work in partnership with its local stakeholders to identify where personal health budgets would be most beneficial for its diverse local population and stimulate the local market to ensure that there are quality choices for people to spend their budget on. G&WCCG will ensure that in producing its local personal health budget offer it has given due regard to legal duties for equality and health inequalities.
12.5.3 In introducing a Personal Health Budget Strategy G&WCCG will consider three important questions when developing its local offer:

1) **What does the CCG want to be doing differently that will enhance a positive outcome for individuals?**

Think laterally in how limited resources can be used more creatively to improve individualised health and wellbeing outcomes.

2) **What problem is the CCG trying to solve by introducing Personal Health Budgets?**

There is a reliance on overstretched services that don’t always meet people’s needs in a personalised way. It is anticipated that for some individuals a personal health budget will facilitate access to resources that fall outside of traditional health service provision and meet their individual need and preference in a way that is meaningful to them.

3) **Who is not well served by current services?**

Individuals who repeatedly access health services but where additional positive outcomes could be achieved through the use of a personal health budget that meets their individual needs and preferences within their local community.

12.5.4 Table 1 below outlines the CCG commitment to develop its local PHB offer to support children with complex needs, those with mental health and those living with learning disabilities to help them to reach their full potential by using resources in an alternative way.

<table>
<thead>
<tr>
<th>Critical Milestones</th>
<th>CCG Lead</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with key stakeholders to establish who needs to be involved in developing the local PHB offer</td>
<td>Children’s and Adults PHB Leads</td>
<td>Summer 2016</td>
</tr>
<tr>
<td>Establishing stakeholder events to support the process of developing the local offer</td>
<td>Children’s and Adults PHB Leads</td>
<td>Summer 2016</td>
</tr>
<tr>
<td>Agree with key stakeholders on a G&amp;W PHB policy</td>
<td>Children’s and Adults PHB Leads</td>
<td>Autumn 2016</td>
</tr>
<tr>
<td>Clarifying the cohorts of individuals entitled to a PHB, e.g. children with complex needs, those living with mental health problems or learning disabilities</td>
<td>Children’s and Adults PHB Leads</td>
<td>Autumn 2016</td>
</tr>
<tr>
<td>Agreeing with key stakeholders on the</td>
<td>Children’s and</td>
<td>Autumn 2016</td>
</tr>
<tr>
<td>application process for a PHB</td>
<td>Adults PHB Leads</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Developing a communications strategy to ensure that all key stakeholders have access to information regarding the local PHB offer</td>
<td>Communications Manager</td>
<td>Summer 2016</td>
</tr>
</tbody>
</table>

**Table 17: Local PHB deliverables**

12.5.5 From April 2015, all CCGs were required to develop plans for a major expansion of personal health budgets, and to ensure that people with learning disabilities are included by April 2016.

12.5.6 The plan for 2016/17 is to create a truly integrated community service offer for all age Learning Disability population. We will develop an integrated approach to specialist support provision, determining packages of support that can be tailored to individual needs.

12.5.7 We will work with the host NHS commissioner for learning disability services, local authorities, key stakeholders and local health and social care providers to develop a local offer to those individuals living with learning disabilities who would benefit from a personal health budget. We will establish the current provision, gaps in provision and service improvement requirements to address these gaps detailed in the LD Strategy Delivery Plan.

**12.6 Francis Report**

12.6.1 A key finding from Sir Robert Francis’ investigations into the failings at Mid Staffordshire NHS FT was of the role that workplace cultures play in supporting (or discouraging) staff to raise concerns.

12.6.2 This insight was the basis for a further focused inquiry into the reporting culture across the NHS. The review, instigated by the Secretary of State for Health and led by Sir Robert, was tasked with identifying measures that would, “help to foster a culture in the NHS in England where staff can feel safe to speak out about patient safety, as well as learning lessons from the existing culture in the NHS by listening to those who have experiences to share, both positive and negative.”

12.6.3 The Freedom to Speak Up review reported in February 2015, and outlined twenty principles and actions for implementation, grouped under five themes:

- Culture change;
• Improved handling of cases;
• Measures to support good practice;
• Particular measures for vulnerable groups;
• Extending the legal protection.

12.6.4 In response to Sir Robert Francis’ Freedom to Speak Up review, Monitor, NHS TDA and NHS England are proposing to undertake a consultation process for a new national whistleblowing policy.

12.6.5 During 2016/17 we will work to implement the following:

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS G&amp;WCCG will participate in the consultation process regarding the proposed national Whistleblowing policy</td>
<td>June 2016</td>
</tr>
<tr>
<td>A standing section in GWCCG’s NHS Providers’ Status Report of Serious Incidents will review compliance on Duty of Candour expectations</td>
<td>April 2016</td>
</tr>
<tr>
<td>Serious Incident Learning Events held in 2016/17 will have a focus on the Duty of Candour</td>
<td>April 2016</td>
</tr>
</tbody>
</table>

Table 18: Freedom to speak up critical milestones and deadlines

12.7 Patient Safety

12.7.1 The CCG’s responsibility for patient safety is discharged through through the Quality and Clinical Governance Committee, with the Director of Nursing, Quality and Safeguarding providing the executive lead.

12.7.2 The CCG continues to implement national recommendations from a range of enquiries following serious quality failings (e.g. Francis report (section 12.1), Winterbourne View/Transforming Care (section 12.1) and the Berwick review of improving patient safety for patients in England(2013).

12.7.3 To address Berwick recommendations, and build resilience in the safety service, the CCG has increased capacity to ensure that the following, are fully implemented:

• Maintain a full and comprehensive patient safety investigation report archive
• Timely reporting of incidents on the Strategic Executive Information System (STEIS)
• Greater and more in-depth thematic analysis of both ‘types’ and ‘root causes’ of incidents
• Ensure that actions from Serious Incident Sub-Committee meetings run effectively with actions followed up
• Ensure that learning from incidents is disseminated appropriately, regularly, and through an annual conference that is Surrey-wide and in collaboration with neighbouring CCGs.
• Ensure there is an improved review and closure process for serious incidents relating to Child and Mental Health Services (CAMHS). Particular improvements include:
  ▪ Improved reporting on rates, timeliness, themes
  ▪ Improved closure times
  ▪ Improved identification of trends, risks and themes and correlation with incidents that occur in Adult Mental Health Services

External audit of Serious Clinical Incident Sub-Committee

12.7.4 An independent review of Serious Incidents was conducted by the CCG’s Internal Audit provider with an outcome of ‘substantial assurance’ awarded in October 2015.

Engagement with stakeholders

12.7.5 It is a priority for the CCG to work collaboratively with the local health and social care economy to address aspects of patient safety and ensure that lessons learnt are shared across the system.

12.7.6 The CCG will hold a Serious Incident Conference in April 2016, to promote and enhance the sharing of learning from Serious Clinical Incidents for acute, mental health, community and maternity care with the following speakers:

• NHS Regional Team to present learning from other areas
• Clinical Human Factors expert
• Representatives from the Patient Safety Collaborative
• Chief Executive from Action Against Medical Accidents
• Plenary discussion with local representatives from a range of sectors.
National Initiatives for Patient Safety

Patient Safety Collaborative

12.7.7 The CCG are active participants in the various work-streams being managed through the Kent, Surrey and Sussex Patient Safety Collaborative, taking forward actions required by CCGs, encouraging and supporting the initiatives within the Commissioned Services.

12.7.8 There has been good progress in the work-streams associated with pressure damage with the CCG being able to report a noticeable decline in the rates reported as serious incidents.

12.7.9 The CCG has taken a greater leadership role in the safe discharge workstream. For the workstream of medication errors, the CCG received a number of awards at a recent collaborative event, including innovations in polypharmacy and care home medication reviews.

Patient Safety Campaign

12.7.10 A patient safety campaign is one of a set of national initiatives to support the NHS in improving the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save lives.

12.7.11 Healthcare is high risk and mistakes can happen. Only safe healthcare services are truly efficient, effective and able to offer the best experience – patient safety is the organising principle of the high quality healthcare we all want to provide. Sign up to Safety is helping to make improvements and create a supportive, open and transparent environment for patients and staff.

12.7.12 The CCG have developed their own safety plan which has been submitted to the Sign Up to Safety Campaign. They also regularly review the progress of the safety plans submitted by their Commissioned Services.
12.8 Risk Management in Partnership

12.8.1 It is recognised that there are risks on individual risk registers that cannot be addressed without a collective response. The local health and care economy recognises the need to implement an approach to jointly manage risks with all relevant internal and external stakeholders, and to be clear about our respective risk appetite for new and innovative approaches to delivery in the context of financial and other constraints. We will develop and monitor a Collaborative Whole System Risk Register and Management approach, as part of the development of governance arrangements for the Surrey Heartlands STP and delivery of the new whole system targeted operating framework.

12.8.2 Effective risk management is inextricably linked to the CCG’s Quality Strategy (2014-2016) which has achieved excellent progress over the last twelve months, with oversight by the Quality and Clinical Governance Committee.

12.8.3 The strategy has a number of actions which will be carried forward into 2016.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Milestones</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Possess Robust Quality Information</td>
<td>Systematic scoping of Information in the media and systems to feed into the quality dashboard</td>
<td>31/06/2016</td>
</tr>
<tr>
<td></td>
<td>Develop systems for correlation of sub-optimal areas of quality with the risk register</td>
<td>30/09/2016</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>
<td>30/09/2016</td>
</tr>
<tr>
<td>To Prevent Sub-Optimal Quality</td>
<td>To develop a systematic feedback of quality Information from regular clinical visits to the quality dashboard</td>
<td>30/09/2016</td>
</tr>
<tr>
<td>To Establish Expectations of Quality</td>
<td>To establish formalised data returns on quality schedules from providers and ensure their implementation within the quality dashboard</td>
<td>30/09/2016</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>
<td>30/09/2016</td>
</tr>
<tr>
<td></td>
<td>To review performance and take decision on compliance to both CQUIN and QP</td>
<td>30/09/2016</td>
</tr>
<tr>
<td>Goal</td>
<td>Milestones</td>
<td>Target Date</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>schemes</td>
<td>To develop, in all formal meetings with commissioned services, an opportunity to celebrate key successes in quality</td>
<td>30/09/2016</td>
</tr>
<tr>
<td>To Work Collaboratively To Achieve System Wide Quality Improvements</td>
<td>To feedback via the Quality report, discussions and decisions from Quality Leads Meetings</td>
<td>30/09/2016</td>
</tr>
</tbody>
</table>

Table 19: Quality Strategy 2016/17 critical milestones and deadlines

12.8.4 In its quest to improve quality and safety the CCG will continue to perform and enhance the following functions during 2016/17:

- Strengthen our organisations resilience to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.
- Support and engage with the Patient and Public Engagement Group and the Network of Chairs of Patient Participation Groups from all General Practices. This affords the opportunity to share with the CCG any quality concerns picked up from their own engagement activities within the community.
- Review the results of patient surveys such as those issued by the Care Quality Commission and review the action plans produced by the relevant Commissioned Service provider.
- Be transparent with people about our progress to tackle patient safety issues - for example by adhering to our ‘Being Open’ policy when investigating serious incidents - and support staff to be candid with patients and their families.
- Monitor our commissioned services compliance with the ‘Duty of Candour’ both through the NHS contract and the Commissioning for Quality and Innovation Schemes;
- Provide a complaints service in accordance with NHS England guidance and report to the Quality and Clinical Governance Committee;
- Employ staff within the Quality department with sufficient knowledge and experience as a source of advice and guidance in all quality improvement initiatives performed by the organisation.