SURREY

NHS

Surrey Heartlands

Sustainability and Transformation Plan

October 2016

Executive Summary

This document builds upon and should be read in conjunction with the submission of 30 June (attached for ease of reference)**.** It is our third submission to the national Arms' Length Bodies (ALBs) and is not a final plan, but an update on our progress and the outstanding challenges we face. It is also a further request for support, practical and financial (transitional), from the national ALBs who regulate the NHS – as without this support this plan will not succeed. The document has been agreed in public by our Committees in Common.

Surrey Heartlands serves 850,000 people with a combined health revenue allocation of £1bn and combined social care and public health budget of £328m. Compared to national distribution, Surrey Heartlands has a much larger population aged 40 – 65 and 75+. Over the next 10 years the number of people aged 85+ will go up by 36% and by 2025 more than 20% of the population will be aged 65+.

NHS-funded care in the Surrey Heartlands area is commissioned and delivered by multiple organisations. This complexity has in the past inhibited efforts to tackle the significant challenges faced by the local health and social care system – demographics, workforce and infrastructure. Our opportunity, working as a STP footprint, is to address these challenges as a system, enabling us to achieve 'more than the sum of the parts'. This will also require a change in how we are held accountable as individual organisations.

At the heart of our STP is a commitment to work together as a system to transform public services and secure consistent, sustainable, high quality physical and mental health and care for the people of Surrey Heartlands for the long term.

Since June we have achieved commitment to take forward a number of well defined, practical programmes of joint working to fulfil our ambition. This is supported by a strong track record of collaborative delivery on the ground.

We have also started a deliberative programme of public engagement to involve citizens in defining the priorities and trade offs we will apply to achieve this service transformation, within the resources available locally. Devolution (see p10) will enable full integration with Surrey County Council, integrating health and care delivery with the wider determinants of health in our population and realising the benefits to health of contributing to the macro-economics of the local landscape to deliver maximum public value.

If we deliver this plan, we will have instituted consistent pathways and standards of care in each of the disease areas that most affect local people, supported by a scaled up prevention strategy involving all public services. We will have ensured there is an integrated model of proactive support for people with multiple complex health and care needs at locality level, which is not impacted by organisational boundaries. We will have developed a sustainable, motivated and high quality workforce that is able and enabled to work across organisational boundaries, integrating health and social care and physical and mental health care at the point of a person's need. We will have optimised the value of our physical assets and support workforce to minimise duplication and channel resources to the front line; and information in support of care will be seamless and available to all professionals.

We have made good progress since our June submission

We have reflected on our engagement with the national Arms' Length Body chiefs, and subsequently received feedback, following our previous submission:

We were asked to:	**We have:**
• Build on the clear progress made in moving the plan forward, and take this to the next level by clearly setting out the clinical case and specifying timeframes to accelerate the delivery of clinical pathway redesign • Ensure the benefits from collaborative working across providers can be driven at pace.	Developed the Heartlands Academy model to create a collaborative mechanism for clinical transformation; used our clinical workstream mandate groups to define the early priorities and longer-term plan for change
• Provide further detail on how both the Out of Hospital/Primary care and Acute Operating Models will be implemented. • Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health.	Established the process and timelines for transformation of our system architecture, across the acute, community and primary care systems, for both physical and mental health, ensuring we draw on the best of local models and the benefits of operating at scale where appropriate
• Engage with SW London STP to better understand assumptions regarding changes in patient flows	Continued to engage with South West London, Frimley and Sussex and East Surrey. SW London's acute strategy remains under review but we have retained flexibility to work with a number of scenarios

We have continued to enhance the organisational buy-in and support for the STP via Chief Executive/Transformation Board level sponsorship of each workstream within the STP, and a wide membership of mandate groups ensuring adoption of STP initiatives within organisation-level strategies.

The success of our strategy is dependent on a number of key asks for support from national bodies. These remain largely the same as our 30 June submission

1. Early access to transformation funds to accelerate delivery of integrated out of hospital systems and development of primary care. We have noted the funding for primary care available to Access Fund sites set out in the planning guidance. Under these provisions, funding for extended access will only be available to cover a quarter of the catchment which was granted a Prime Minister's Challenge Fund (PMCF) scheme; we need funds to support the whole STP footprint area.

As we set out alongside our 16th September finance submission, if funding is released early we remain able to cover the majority of identified transformational requirements from our indicative £56m STF funding and release of the 0.5/1% non-recurrent reserve. Any strategic capital requests could be significantly mitigated via receipts generated under a One Public Sector estate strategy.

Furthermore, early access to funding of £1.2m in 2016/17 in order to generate management capacity for the STP is now critical. The consequence of transformation funding not being available would be that either the investment requirements become cost pressures in 2017 – 19, leading to larger in-year deficits; or that the transformation programme slips, leading to a position where the STP is only able to deliver business as usual efficiencies against the 'do nothing' cost pressure.

2. ALB support to accelerate the Surrey Heartlands Devolution proposal, including an integrated place-based budget, with NHSE and NHSI working together with Surrey Heartlands as a system, and individual organisation regulation being exercised in this context.

We are also seeking the **devolution of relevant specialised commissioning budgets** on a population allocation, allowing us to integrate specialised commissioning pathways into the work of the Academy and build our centres of excellence. We can offer an increased level of grip, control and responsiveness in dealing with specialised services pressures.

3. Integration of health into the Surrey County Council One Public Estate pathfinder project, with full local control of NHS infrastructure (estates and digital) and devolution of capex. Through our devolution proposal we will optimise opportunities for alignment of health to Surrey County Council, enabling more innovative solutions for raising funds, procuring services, and recycling the dividends of transformation to support investment in services.

4. Ongoing progress on the **estates solution for Epsom and St Helier.**

5. Approval to establish an adult social care precept that fully reflects demographic pressures.

We have continued to develop the aspirations set out in our June submission

GAPS

- Existing financial pressures
- Demand growth – older, more complex patients
- Lack of integrated treatment approaches
- Acute sector already at full capacity
- Digital integration and innovation
- Unsustainable workforce model
- **£102m recurrent gap by 2020/21**

OBJECTIVES

Achieve consistent clinical pathways & remove unwarranted variation	Deliver a system which is sustainable and designed to deliver quality, efficiency and access in care in physical and mental health	Secure buy-in for change and personal responsibility for health	Speak with one voice and act with one mind

INITIATIVES

Heartlands Academy - £45m via our clinical workstreams:	**Specialist Acute Operating Model (inc. MH) - £15m**	**Citizen-led Health and Care approach**	**Shared accountability**
Cardiovascular - £12.7m	**Local Integrated Care Operating Models (inc. MH) - £11 – 23m**	**Prevention Strategy £15.2m**	**Back-office efficiencies - £10.1m**
Cancer - £8.8m	**Primary Care Operating Model**	**ASC precept change - £8.4m**	**Estates strategy - £8m**
Mental Health - £0.5m	**Workforce transformation**		**Digital transformation**
MSK - £8.6m			
Women's & Children's - £1.0m			
U&EC - £13.8m			
Other RightCare opportunities - £11m			

£115m - £125m of efficiencies by 2020/21 **supporting aggregate financial balance**

There are a number of areas we continue to develop together

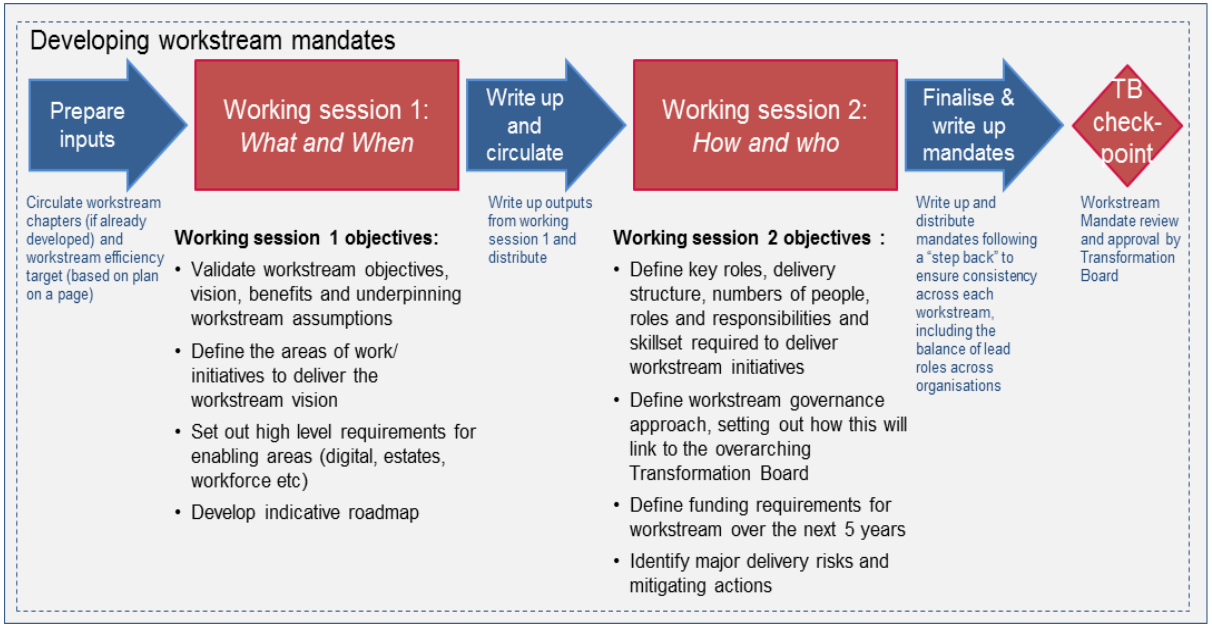
There is strong support to the detailed programme mandates summarised in the Annexe to this pack. The Surrey Heartlands Transformation Board recognises the complex challenges faced by member organisations and we have identified a number of 'system management' priorities for further detailed work-up. This will enable us to ensure effective support to the delivery of transformation on the ground:

- **Accountability for financial and operational delivery** – we have noted within operational planning guidance for the NHS, the potential to move to single 'system control totals', i.e. shared accountability for financial performance. We have explored a set of working principles that would allow this to take place, with a number of benefits including being able to divert management resource away from the PbR trading mechanism and into supporting service transformation. With the publication of individual organisational control totals and the messages being received in respect of the priority of these over shared accountability, we have reviewed the deliverability of a single control total for the STP footprint in 2017/18 and plan to apply a phased approach. The application of the system control totals will be tested in 2017/18 in the North West Surrey and Surrey Downs systems, whilst working to agree an integrated process from 2018/19 across the STP. In the meantime all systems will pursue new contractual models to underpin locality based integrated care systems in 2017/18. We will also introduce a mechanism that will allow us to track in aggregate the impact transformation is having on system operational and financial performance at STP level.
- **STP governance and oversight** and ensuring this is aligned with, and supported by, existing systems of oversight, many of which operate on a different footprint but are statutory in nature. We will work to define a robust governance and decision making process to support application of a single control total mechanism in readiness for implementation across the footprint in 2018/19.
- **Geographical focus for transformation –** we will build upon our localities where we recognise the importance of preserving and protecting critical GP engagement to focus on delivering models of integrated out of hospital health and social care closer to home as a critical driver of the wider system. At STP level, we will focus on the areas where working at scale across our footprint brings benefit. We will continue to work as a footprint to share best practice, holding each other collectively accountable and supporting local delivery.
- **Relationships with other STP areas –** Surrey Heartlands operates in a densely populated part of the country, close to London and a number of other strong systems. There are established clinical, operational and commercial relationships across these boundaries which remain important. Our challenge is to agree, for each of the areas where this challenges our transformation plans, how we approach that interaction as a Surrey Heartlands team, leveraging relationships to deliver benefits for patients and services across the STP area.

We have developed each workstream into a clearly defined programme of work

Since July, we have run a process of building out each workstream as a programme of work, owned by a Transformation Board member. We have:

- Established mandate groups for each workstream with a Transformation Board member as an Executive sponsor;
- Re-confirmed each workstream's assumptions, clarified workstream priorities, identified resourcing requirements, mapped out key interdependencies and developed detailed programme roadmaps, following a standard process in each area (set out below):



We have had significant levels of clinical input and agreement at the Transformation Board. The next stage is to broaden this clinical engagement across the STP.

It has been supported by TB-level discussions on shared planning round principles, programme resourcing and governance, and key elements of system architecture.

These discussions have led to the appointment of a Transformation Director and Programme Lead, from secondments within the STP. These two appointments blend experience of acute hospital operations, strategy and transformation with local government transformation, governance and accountability, reinforcing the cross-sector working which has characterised the process to date.

Our programme structure has evolved to ensure we create capacity but retain ownership across local organisations

Previous 15 workstreams

- Out of Hospital and Primary Care
- Acute Operating Model
- Prevention
- Surrey Heartlands Academy
- Cancer
- Cardiovascular
- Mental Health
- Women's and Children's
- MSK
- U&EC
- Citizen Led and Engagement
- Workforce
- Business Support Services
- One Public Estate
- Digital

Sovereign Boards/ Cabinet

Joint Committee

Transformation Board

We have recognised that whilst delivery at scale and pace is critical, we need to ensure ongoing active buy-in to the STP from all organisations, and at every level. The structure shown here supports this by facilitating

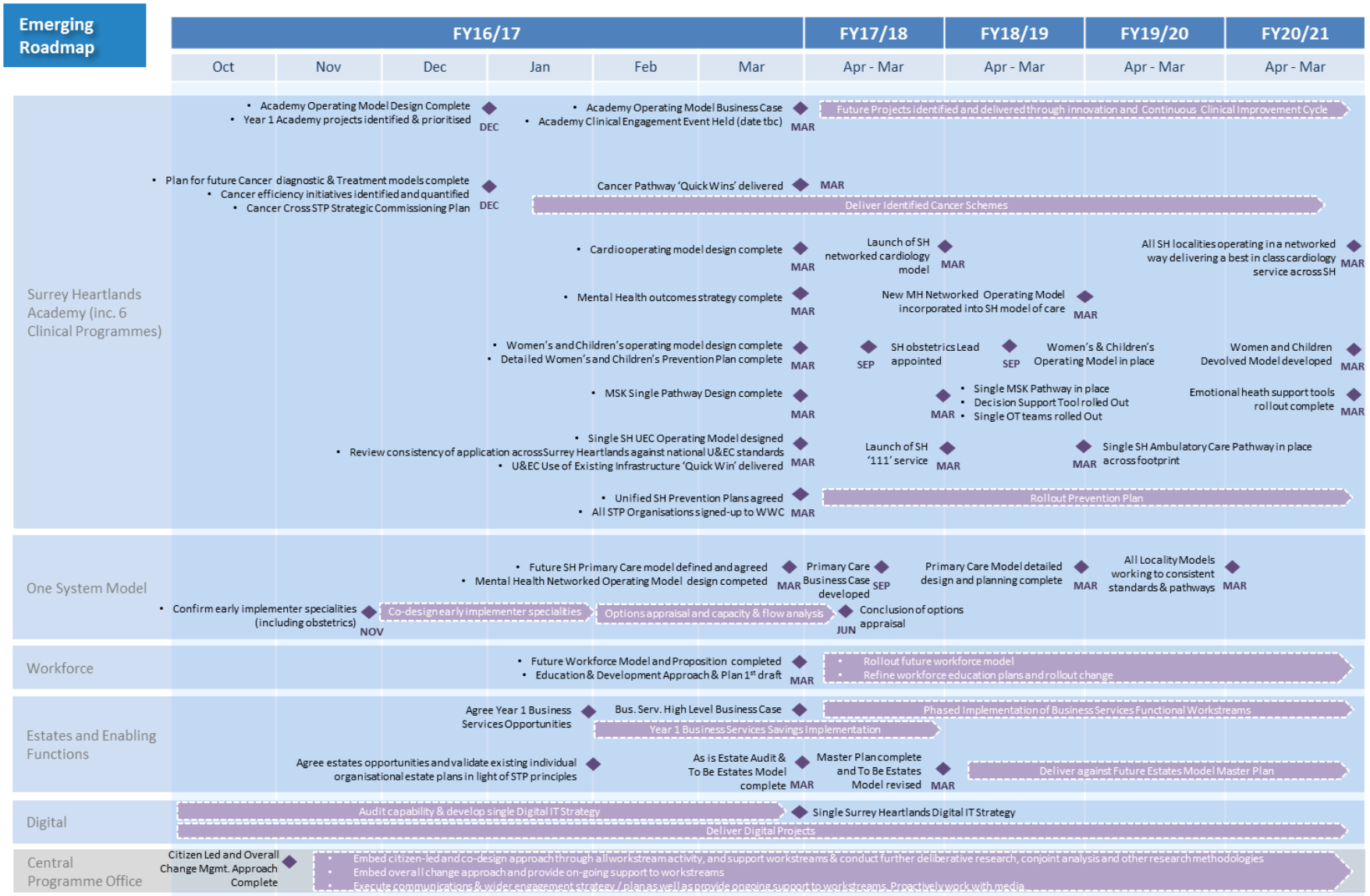
- CEO Chairmanship of each Programme Board
- A Programme Board for clinical change, supported by the Academy philosophy
- Integrated oversight of heavily co-dependent transformation areas
- A clear link into proposed devolution-based governance mechanisms

Programme Boards	***Rationale***

1. Surrey Heartlands Academy
Clinical Change Board: Cancer; Cardiovascular; MH pathways; MSK; Women's and Children's; U&EC; Prevention
	• Positions the Academy as key differentiator and core Surrey Heartlands enabler that will:
	  • Act as the collaborative mechanism for a common, structured and consistent co-production process to service design and change
	  • Challenge unwarranted variation in practice
	  • Embed prevention throughout

2. One System Model (Physical & Mental Health) Local Integrated Care Operating Models; Specialist Acute & Mental Health Operating Model	• Ensuring best practice and adoption of innovation from local mental, physical, health & social care integrated models • Addressing sustainability in acute
3. Workforce Workforce	• Single point of focus on short term issues and future workforce model
4. Estates and Enabling Functions Business Support Services; One Public Estate	• Synergies around jointly identifying and implementing initial efficiency savings • Longer term unified strategy and single point of Executive Sponsorship.
5. Digital Digital	• Workstream co-owned and sponsored with the Local Digital Roadmap initiative
…. Embedded within the central programme team Comms & Engagement; Change; Citizen Led	

Once complete, mandates will form the basis of a detailed roadmap



Surrey Heartlands

SURREY NHS

Our devolution proposal offers us an opportunity to maximise the value of public service delivery in Surrey Heartlands

We have discussed, with NHS England and the Department of Health, a proposal for health and social care devolution in Surrey Heartlands. Securing devolution is about unlocking the potential of the whole public sector system – it will enable us to deliver on our truly radical vision and take the steps to achieving it. Placing health and wellbeing as part of the infrastructure of prosperity and aligning with wider work around education, skills, work and housing, we will secure the best outcomes for the people of Surrey Heartlands.

From a foundation of strong relationships and joint commitment across the system we have set out an ambitious programme for delivery; we wish to pursue devolution as a critical vehicle for realising the benefits and opportunities articulated in our plan. Through a place-based focus, underpinned by a formal devolution agreement, we can drive better outcomes, stronger integration and public value for our population. In short, we believe devolution will enable us to go further and faster to deliver the benefits articulated in our STP, and more.

There are many potential benefits of devolution but two critical drivers we believe would secure delivery of the STP: (1) by creating the conditions within which we operate as a system with fully aligned incentives and the ability to control funding flows to support transformation, and (2) by enabling different approaches to the funding of innovation and transformation for long term 'invest to save' propositions.

The links are clear: vital to bringing prosperity to Surrey Heartlands through jobs and investment is us having healthy and independent people, and people feel and stay healthier when they have jobs, good quality, affordable housing and are part of strong families and active communities.

Key benefits of devolution include:

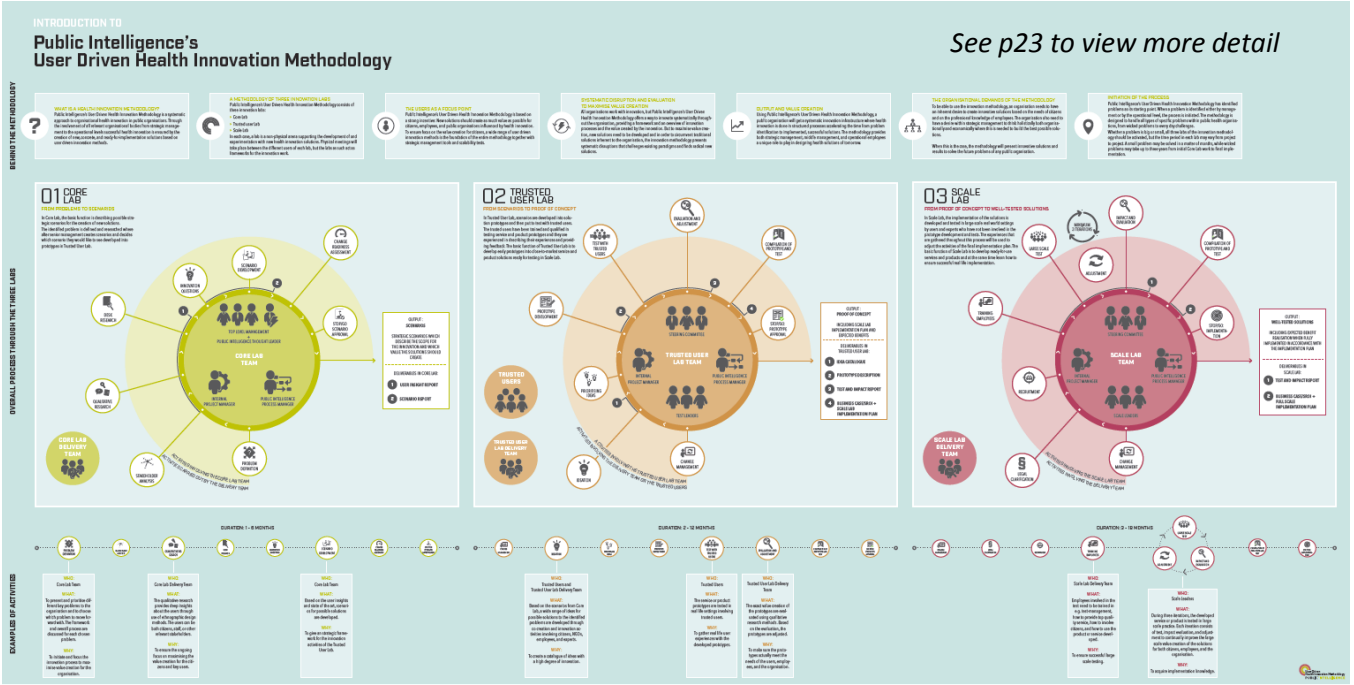
- An **essential local dialogue with citizens** about their priorities in transforming the health and social care system so that it will meet their ambitions for wellbeing and health in a sustainable way. It would enable the engagement of residents in genuine place-based co-design and co-delivery of health and care.
- Help to ensure that **the range of resource and investment** available in Heartlands is focused towards improving the health and wellbeing of the population. In particular devolution would align key elements such as housing, transport, employment and prevention initiatives.
- Enable the freedoms and flexibilities to guarantee we achieve **maximum public value**, for example through innovations in income strategies, procurement, and maximising the potential contribution of 5G connectivity to secure the full benefits of the digital economy. Our devolved approach to our relationship with universities and our Academy will enable us to be **leading edge on digitally enabled self-care**, prevention, real time distance diagnosis and intervention.
- Our One Public Estate pathfinder has the potential to **unlock significant value** through a collaborative place based approach to getting best use out of existing land and buildings.

A Surrey Heartlands Academy will enable co-production and delivery of consistent clinical standards across the footprint

Surrey Heartlands Academy is a key differentiator for our system. The Academy will enable us to provide best evidenced, best value, excellent health and social care for our citizens. Working in partnership with the AHSN, University of Surrey, Surrey Health Partners and the health system in Southern Denmark, we will adopt and adapt a rapid user driven innovation methodology (see below), starting immediately with our Urgent & Emergency Care Pathway.

Building upon our existing work with Southern Denmark's Public Intelligence Team in the Dementia Innovation Test Bed, our ambition is to:

- Build a common, structured and consistent co-production process to service design and change
- Establish a physical space that will provide a neutral environment with the right conditions to promote innovation and design
- Create an investment framework that enables us to fund the work by active partnerships with industry



Working with Public Health, the Academy will also focus on the evaluation of key elements of the STP, starting with the Out of Hospital work taking place in each of our localities.

We will build upon our Technology Integrated Health Management (TIHM) Test Bed

TIHM (Technology Integrated Health Management) for dementia is one of 7 national Innovation Test Beds and 1 of only 2 focused on developing an Internet of Things for health. TIHM is funded by NHS England and Innovate UK and sponsored by the Department for Business Innovation and Skills. TIHM aims to understand how cutting edge technology placed in people's homes could be used to improve the lives of people with dementia and their carers.

A dynamic delivery partnership has been created between Surrey and Borders Partnership NHS FT, the Kent, Surrey and Sussex Academic Health Science Network, the University of Surrey 5G Innovation Centre, Royal Holloway University, the Alzheimer's Society and Public Intelligence Denmark. We are working with 9 innovation technology companies and health and social care partners across the patch, including local CCGs, the County Council and primary care. The project will:

- Enhance quality of life of people with dementia and their carers.
- Improve health and care outcomes by enabling people to stay at home longer and reduce hospital bed days.
- Test interoperable combinations of devices using open APIs and HyperCat with the ability to scale nationally and internationally, creating a connected system with the ability to be applied to other use cases.
- Develop personalised and targeted care by using machine learning methods to predict risks and decline in health status.
- Drive change in workforce practice and cascade learning into dementia care pathways.
- Deliver improved care and better value for the health and care economy.

A high quality evaluation based on randomised control trial methodology and rapid cycle innovation is helping us to understand how technology can optimise use of health and social care resources and produce better outcomes for people. Our aim is to phase the spread of learning and application of TIHM to other long-term conditions across the STP footprint, before extending to the KSS region and then UK wide.

Outcomes so far have been:

Collaboration agreement – which sets out how IP and commercial spread will be dealt with at the end of the two year project

Co-design - working with people with dementia and carers through our work with Alzheimer's Society and creating a user community

Technical build – Two Living Labs are running at the Clinical Research Unit at Surrey University where devices, apps and sensors are being tested for their optimal configuration through a rapid innovation cycle

Clinical Pathway reconfiguration - using co-design methods we have created a new pathway of care enabled by technology to be tested in the trial. We are now deploying a "Living Lab" ethnographic methodology used in Denmark

Security Standards work – Royal Holloway has developed an architecture to protect the security of patient data and resilience of networks

The support we now need:

NHS England support and funding to deliver widespread benefit across the UK

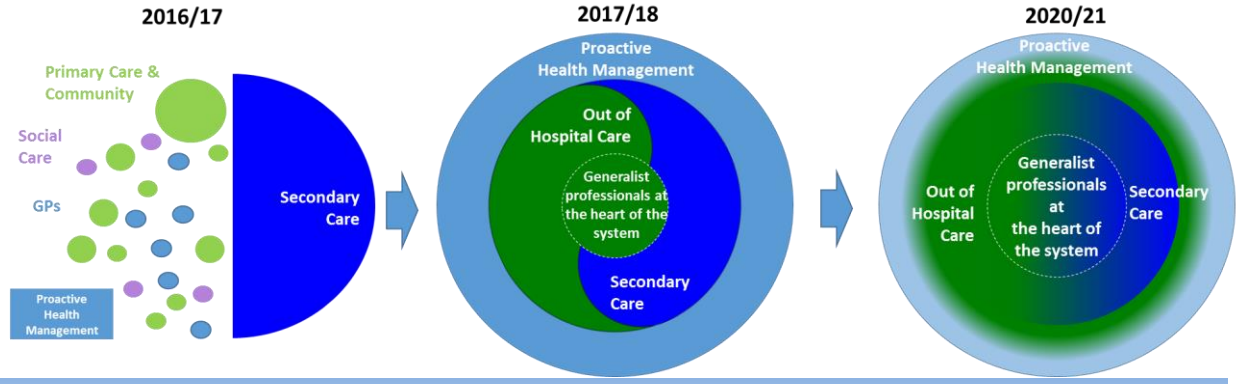
Our out of hospital models blend local delivery with STP-level support and learning

Building on two years of successful BCF health and social care integration, including the pooling of budgets, we are now moving to integrated, primary care led out of hospital models which are critical to delivering a new approach for the complex frail patients who form a rapidly growing part of our population. We continue to recognise the requirement for a local, bottom-up approach with STP level agreed principles, oversight, development and learning.

Our actions underway are to:

- Continue with existing CCG plans for each Surrey Heartlands locality and **at least 1 locality per CCG to apply for additional MCP/ PACs support** in order to accelerate delivery, with integration of health and social care at the heart of the proposal. Some case studies showing the detailed difference these services are making are contained on the following pages. However these models require funding and support to scale up and deliver their full potential
- Run a **clinical leadership development programme across Surrey Heartlands**, building upon the work currently taking place in Surrey Downs CCG in order to enable future delivery
- Commence **peer review of locality out of hospital/health and social care integration models via the Surrey Heartlands Academy**

Over the life of the STP our model will progress towards integrated systems sharing key principles



Local delivery systems reflecting specific demographics and infrastructure already in place

East Elmbridge CMSP

Dorking CMSP/ PCH bid

Epsom Health and Care

Thames Medical

Woking

SASSE

Integrated Hubs/primary care at scale in North West Surrey

Guildford and Waverley proactive care

Our delivery of new models of care has begun at pace – Epsom Health and Care

Epsom Health and Care was established in 2015 following a bid for Vanguard status led by Surrey Downs CCG, Epsom and St Helier University Hospitals NHS Trust, Central Surrey Health, the local GP federation and Surrey County Council. This partnership of equals, including a strong GP voice via a federation, has been key.

Although the bid was not successful, the organisations committed to working together to transform care for complex, elderly patients and their carers living in the Epsom area. The CCG committed its entire efficiency requirement for non-elective care in the Epsom area to be delivered through EHC for the 2016/17 planning round, resulting in a business case delivering substantial savings, but with a substantial investment requirement.

During planning, was clear that the CCG could not take the risk of making the investments and the transformation not delivering 'PbR savings' of reduced admissions. At the same time, the Trust could not absorb the PbR impact of the activity reduction assumptions being made, and deliver its control total.

The CCG and Trust approached NHS England and NHS Improvement with a proposal (subsequently agreed) that both organisations should move their control totals to enable the transformation, with the Trust hosting the Epsom Health and Care alliance which would receive the investment funding and deliver the transformation, on the basis of moving non-elective care out of payment by results for the 2016/17 year. In November the alliance will take responsibility for the winter resilience scheme for enhanced primary care in Epsom A&E and are exploring with the CCG, a wider role in planned care pathways. As with all models, the EHC model will be peer reviewed through Surrey Heartlands Academy.

Outcomes so far have been:

- 871 patients managed through community hub
- 25 – 30 patients a week using new @home rapid response service
- Epsom site continual delivery of A&E standard for 12 consecutive weeks
- 8.4% reduction in acute length of stay for unplanned admissions
- 25% reduction in bed days attributable to delayed transfer of care

The support we now need:

- Endorsement and support for EHC to be formally recognised as a PACs in shadow form for 2017/18 and with potential full budgetary devolution in 2018/19
- NHSI support to maintain contractual arrangements in support of transformation

Our delivery of new models of care has begun at pace – Locality Hubs in North West Surrey

The Bedser Locality Hub opened in December 2015 and is the first of three locality hubs planned for North West Surrey. The model has been recognised by the Royal College of Physicians and accepted into its Future Hospital Development Programme.

Locality Hubs offer a fully integrated GP-led, multi-disciplinary 'one-stop-shop' service for the frail elderly in the community. Hub unique attributes include:

- Primary care leadership of all out of hospital services, weaving together multidisciplinary care in a common and aligned pathway, including social care and District and Borough services, with consultant sessions in the Hub
- Provides both proactive (for stable) and reactive care (for exacerbations), with a focus on prevention, encouraging self-care, identifying risk factors and managing these early
- Provides support for carers
- Interventions delivered in a physical setting by a single integrated team, based on a holistic '7-element care plan'
- Wellbeing co-ordinators provided by the voluntary sector as named key workers for all clients, ensuring access to all relevant support within and beyond the Hub
- Socialisation and engagement activities at the group and community level - including provision of exercise classes in the Hub
- Transport provided for all clients to enable attendance at the Hub
- Patient contact frequency and intensity is optimised for meaningful engagement
- Fully integrated as part of our wider Discharge to Assess pathway

Next steps are to:

- Secure capital funding to open Hubs across our localities (serving a further 10k patients)
- Support provider partnerships through mobilisation of the adult community services contract and deliver extended primary care access centres through PACS and MCP models.
- Remodelling walk in centres to enable practice networks in three localities to accelerate delivery of on the day primary care access at scale

Outcomes so far have been:

- 902 patients on the Bedser hub caseload, with numbers increasing week on week (goal to reach c. 5k during 2017/18)
- An average of 130 MDT appointments delivered each week.
- Emergency admissions for the over 75s in Woking are reducing, tracking 4% below neighbouring localities
- 572 Bedser hub patients have care plans uploaded onto SECAMB IBIS system
- Conveyance rate to A&E for Bedser hub patients 8.5% below NWS average

The support we now need:

- Capital investment funding to allow development of the locality hubs in Ashford and Weybridge.
- Transformational funding to support development of PACS/ MCP model to realise the full vision of the new model of care

Our delivery of new models of care has begun at pace – Guildford and Waverley

Guildford and Waverley have had discussions with our local providers over some years about the creation of some form of accountable care system based around an equal partnership alliance based agreement. These discussions also included the University of Surrey utilising their expertise in data management to stratify patient populations to assist in targeting care approaches to achieve improved outcomes i.e. reductions in acute interventions

Last year acute, community, primary care, mental health and social care providers worked with the CCG to set up a Guildford and a Waverley community based hub where integrated teams of professionals , from both health and social services, deliver coordinated care for patients who are vulnerable of an unplanned hospital admission

These hubs support 5 locality groups of GP practices who ensure that the multi disciplinary working is delivered on the ground. A key feature was the care home pilot which provided concentrated support which successfully reduced admissions and is now being rolled out across the area.

These changes resulted in significant improved outcomes including overall reductions in unplanned admissions and more effective support for people with complex health needs and their carers. We are clear through evaluation that this has only been achieved by close working across the primary, community, social care and secondary care interface.

Outcomes so far have been:

- 2015/16 reductions in A&E attendance for the over 65s population 5.0% and 7.0% reduction in non elective admissions
- NEL admissions from Care homes reduced by 10%
- Excess bed days for over 65s reduced 18%.
- Reduction in ambulance conveyances from 1388 in 01/16 to 1307 in 02/16
- The number of IBIS care plans has increased from 3450 in 01/16 to 3580 in 02/16

The support we now need:

- Guildford and Waverley providers and commissioners are committed to working to establish a care system building on the work of the previous years delivery of proactive care hubs.
- We now need to move to an alliance type contract with the acute trust , our GP federation and other partners to deliver further efficiencies in a similar way as the Epsom Health and Care model.

We are prioritising the 10 actions which have been set out to implement the GPFV locally

We recognise the challenges faced by primary care as set out in the GPFV. Our priority as an STP is to develop our practices in a sustainable way. We are taking specific action against the 10 actions identified in the GPFV. We are also developing capability within our GP workforce by running a GP Leadership Development Programme and encouraging all our practices to take advantage of the national GP Development Programme.

Action to take	Surrey Heartlands steps to implement
STPs must plan to invest an increasing proportion of their budget in general practice over the next five years	The financial model submitted 21/10 includes above-allocation growth in primary care expenditure, and £34m of non-recurrent investment in responding to the GP Forward View and delivering the Out of Hospital Strategy (subject to ALB support)
STPs must support the urgent roll out of the GP Forward View practice resilience programme in their local area	Our 3 CCGs have all worked with NHS England to actively identify Practices who would benefit from GP Resilience Programme and encouraging them to submit applications or submitting applications on their behalf
STPs must adopt a specific target for increasing the number of GPs in their area by 2020/21 and put in place a strategy to get there	We have an ongoing dialogue with HEE KSS via the Local Workforce Action Board and are working in each of our CCG areas to develop either GP Federations or practice cluster to move towards new models of working at scale. The Workforce workstream of the STP is engaged in developing the Multidisciplinary Team required to support our Integrated Out of Hospital and Primary Care Strategy such as Pharmacists, Acute Nurse Practitioners, Physician Assistants, Health Care Assistants and Care Navigators to allow teams to work at the top of their "licence" and maximise efficiency without loss of quality. CCGs are supporting individual practices to apply for the funding available under the GPFV Development Programme.
STPs must have a strategy to grow the wider general practice workforce	
STPS must include initiatives to reduce GP workloads	The STP is supporting each CCG to actively engage their GP workforce around the GPFV "10 High Impact Actions to Release Capacity" Although at different stages of evolution the STP is supporting GP Localities and Federations to consider new models of care including working alongside their community, mental health and acute providers in alliance type models of care.
STPs must set out plans to support the development of general practice infrastructure	The STP contains overarching estates and digital roadmap workstreams, a key focus for both areas is supporting the development of general practice infrastructure.
STPs must build capacity in-hours. Decisions about extended GP opening hours must be based on robust evidence regarding patient demand, and must have the support of local practices	Our STP will support GP localities to identify new models for undertaking on the day primary care at scale, releasing time to support management of long term conditions
STPs must support general practice to move towards new models of working at scale, recognising that practices are moving at different speeds and there is no 'one size fits all' approach	The STP includes support for MCP and Primary Care Home vanguard applications across all three CCGs, in line with our commitment to locality-based health and social care integration models, in addition to the support for moving to scale-based models for on the day primary care. This is supported with an identification of £34m in our submission to support primary care transformation (subject to ALB support and release of funds)
STP governance bodies must include front line GP representation	The LMC sit on the Surrey Heartlands Transformation Board
Build in monitoring and evaluation	The creation of the Surrey Heartlands Academy will mean that monitoring and evaluation will become part of the a continuous improvement cycle within Surrey Heartlands. A project has already been identified to conduct a monitoring and evaluation exercise of each of the out of hospital models we have across our footprint. We have identified a resource to run the project.

We are developing an affordable, sustainable and high quality specialist acute operating model

On 30 June we shared a high level approach towards defining a future acute operating model.

This approach has been developed further with all acute hospital CEOs and Medical Directors committing to the principles set out on the right.

Our process is now as follows:

- **October/November 2016:** Secure analytical and programme management support
- **November 2016:** Confirm early implementer specialties (including obstetrics)
- **November 2016 – January 2017:** co-design early implementer changes with clinical teams
- **January 2017:** Full options appraisal commences supported by capacity and flow analysis, learning from early implementer areas
- **January 2017:** early implementer sites move to implementation
- **June 2017:** Conclusion of options appraisal; pre-consultation business case
- **Q3/4 2017/18:** Consult on changes

Principles

1. If a patient becomes unwell they should be cared for at home or in the community wherever possible, if admission is unavoidable it should be to the most appropriate site for their needs
2. If they become acutely sick and require hospital treatment, they will receive a consistently high standard of specialist care that meets agreed quality standards and outcomes
3. Where best outcomes are delivered through networks or alliances beyond the Surrey Heartlands footprint we proactively support and develop these models – e.g. cancer
4. We will review existing patient flows to determine whether the best care is being delivered for our population
5. We should seek to repatriate patients currently exiting Surrey Heartlands for service provision where we can provide care that meets their needs in a timely, high quality and cost effective way and as a minimum provides an equitable and better experience and outcome than is currently being secured outside SH
6. We will achieve best practice through removing unwarranted variation
7. We are committed to using our workforce as one integrated team across our localities to deliver safe and effective care

The integration of physical and mental health care sits at the heart of our plan

Mental Health is an intrinsic element of our STP. Physical and mental health are closely interconnected and our plan lays out a roadmap for delivering the commitments made in the *Five Year Forward View for Mental Health* to people who use services and the public and provides a strong focus on good mental & physical health, threaded through the different workstream mandates, on creating and scaling integrated approaches to service models and on developing knowledge and skills across our workforce to take a **'whole person'** perspective.

We recognise that good health and wellbeing can only be achieved by taking a holistic approach, connecting mind and body, family and friends, community and environment. In managing the challenges of the years ahead **prevention** and **integration of mental and physical health** must therefore become part of wider strategic thinking for our system as a whole, and we believe this is reflected in our overall plan as well as specifically within our Mental Health Workstream Mandate.

To transform mental and physical health outcomes in Surrey Heartlands we will develop **a networked operating model** that connects across the wider health and care system by embedding the principles of integrated mental & physical wellbeing and providing a **seamless interface with the acute operating model and out of hospital care services.**

Through **Estates optimisation** there are opportunities to significantly reduce the gaps in the quality of inpatient provision while contributing towards wider health system benefits through opportunities to co-locate. The capital cost of building a second hospital is est. at £100m. with some £35m. being derived from land sales.

In summary within the new operating model we will prioritise initiatives that **improve experience & outcomes** for citizens of all ages and abilities and **reduce variation** & health inequalities and **deliver and scale at pace**:

Prevention: Citizen-led Health & Social Care

- Establish a Surrey Heartlands Wellbeing Prescribing model
- Develop process of engaging with citizens to co-design self-management options
- Embed self care through implementation of Making Every Contact Count & develop Virtual Wellbeing Centre.

Access to Early Intervention: implement coherent & consistent models and pathways of care including:

- Recovery College – connecting physical & mental health
- Primary Care – Team around a Practice, IAPT expansion to LTC's, MUS, Common MH & SMI
- Extend networked model for children & young people to include Eating Disorders
- Establish Perinatal mental health services
- Expand access to treatment in first episode psychosis
- Increase access to Individual Placement Support for SMI

Managing crisis well: reduce pressure on the acute system , reduce admissions, attendances at A&E and lengths of stay:

- Invest in Enhanced Core 24 Psychiatric Liaison
- Expand model of Crisis Response & Home Treatment 24/7
- Implement Single Point of Access
- Out of hospital networks of support e.g. Safe Haven model

Developing workforce capability and wellbeing

Our five year financial projection for the STP shows an improving position, reflecting the need for early investment

The STP plan before £95m of investments achieves recurrent balance in the final two years of the plan. The deficit of £35m in 17/18 improves to a surplus of £19m in 20/21. For the 2017-19 planning period the STP plan (incl. SCC) shows a £46m deficit. This improves to a 2017-19 deficit of £12m for health on a stand alone basis when the SCC net deficit of £34m is excluded.

The health stand-alone figure is equal to the sum of the NHS control totals from NHSE/I.

Around £50m of 2017-19 investments were planned in the June submission. There is an investment gap for which the only identified source of funding at the time of writing is the CCG 1% reserve, assuming that the nationally controlled portion can be accessed.

This forecast is based on 2016/17 M5 positions, excluding unmitigated risks of £18m across health organisations and certain forecast risks in SCC.

We have included control totals for provider Trusts and CCGs as published by NHS Improvement and NHS England. These control totals have not yet been agreed through the planning process. The Board of Surrey and Borders FT believe that their published control total wrongly includes the effect of current year land sales in future years and is discussing this matter with NHS Improvement.

	16/17	17/18	18/19	19/20	20/21	5 yrs
'Do nothing' cost pressures						
CCGs do nothing	(11.8)	(45.9)	(58.5)	(67.3)	(87.4)	**(270.9)**
Add back contingency release	-	(9.5)	(9.7)	(9.9)	(10.3)	**(39.3)**
CCGs	(11.8)	(55.3)	(68.2)	(77.3)	(97.6)	**(310.3)**
Specialised commissioning	(1.4)	(7.1)	(13.1)	(19.8)	(27.3)	**(68.7)**
Subtotal commissioner	(13.2)	(62.5)	(81.3)	(97.0)	(125.0)	(379.0)
Trusts	(10.0)	(10.8)	(11.5)	(12.4)	(14.2)	**(59.0)**
Adult social care	(38.6)	(48.4)	(29.6)	(25.5)	(22.0)	**(164.2)**
SABP	1.0	(3.0)	(3.1)	(3.2)	(3.4)	**(11.6)**
SECAMB	(0.5)	(0.6)	0.0	0.0	0.0	**(1.0)**
Total 'do nothing' cost pressures	(61.3)	(125.3)	(125.6)	(138.1)	(164.6)	(614.8)
BAU efficiencies						
CCG QIPP	1.1	10.4	10.6	10.9	11.3	**44.2**
Specialised commissioning	1.4	7.1	13.1	19.8	27.3	**68.7**
Subtotal commissioner	2.4	17.5	23.7	30.6	38.6	112.9
Identified Trust CIP	-	16.5	15.3	15.9	16.5	**64.2**
Identified ASC efficiencies	31.4	16.8	10.2	8.8	7.3	**74.5**
Total BAU efficiencies	33.8	50.9	49.3	55.3	62.4	251.6
Gap before transformation solutions	**(27.5)**	**(74.4)**	**(76.3)**	**(82.8)**	**(102.2)**	**(363.2)**
Transformation solutions	11.7	19.1	23.4	35.8	45.6	135.6
Subtotal other solutions	1.7	20.1	41.9	62.0	75.3	201.1
Residual gap before investments	**(14.1)**	**(35.2)**	**(11.0)**	**15.0**	**18.7**	**(26.6)**
Residual gap before investments - health	*(6.9)*	*(12.0)*	*0.0*	*23.3*	*25.1*	*29.6*
Residual gap before investments - ASC	*(7.2)*	*(23.2)*	*(11.0)*	*(8.3)*	*(6.4)*	*(56.2)*
Investments	*(10.1)*	*(31.5)*	*(23.7)*	*(18.3)*	*(11.7)*	*(95.3)*
Release of CCG system reserves	*-*	*9.5*	*9.7*	*9.9*	*10.3*	*39.3*
Indicative STF					*56.0*	*56.0*
Funding	*-*	*9.5*	*9.7*	*9.9*	*66.3*	*95.3*
Residual gap	**(24.2)**	**(57.2)**	**(25.0)**	**6.6**	**73.3**	**(26.5)**

	17/18	18/19
Residual Gap before investments	**(35.2)**	**(11.0)**
Remove ASC Effect		
Do nothing	(48.4)	(29.6)
Efficiencies	16.8	10.2
Precept	8.4	8.4
Net	**(23.2)**	**(11.0)**
Adjusted (ie health only, before invests	**(12.0)**	**0.0**
Control totals		
NWS	0.0	0.0
G&W	-4.0	-1.8
SDCCG	-3.9	1.0
Commissioner subtotal	-7.9	-0.8
RSCH	-12.0	-8.3
ASPH	6.4	7.1
SaBP	1.9	2.3
SECAMB	-0.4	-0.3
Provider subtotal	-4.1	0.8
NHS system control total	**-12.0**	**0.0**
Gap (-ve) to STP	0.0	0.0

SURREY

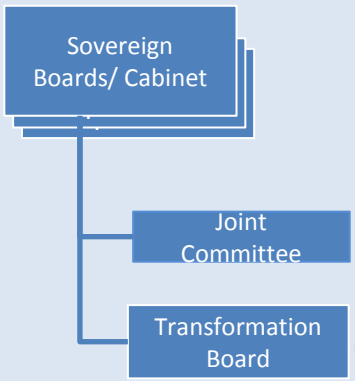
NHS

Surrey Heartlands

Annexe

Mandate summaries

Our transformation initiatives are summarised on the following pages



Programme Boards	Rationale

1. Surrey Heartlands Academy
Clinical Change Board: Cancer; Cardiovascular; MH pathways; MSK; Women's and Children's; U&EC; Prevention
	• Positions the Academy as key differentiator and core Surrey Heartlands enabler that will:
	  • Act as the collaborative mechanism for a common, structured and consistent co-production process to service design and change
	  • Challenge unwarranted variation in practice
	  • Embed prevention throughout

2. One System Model (Physical & Mental Health) Local Integrated Care Operating Models; Specialist Acute Operating Model	• Ensuring best practice and adoption of innovation from local integrated models • Addressing sustainability in acute
3. Workforce Workforce	• Single point of focus on short term issues and future workforce model
4. Estates and Enabling Functions Business Support Services; One Public Estate	• Synergies around jointly identifying and implementing initial efficiency savings • Longer term unified strategy and single point of Executive Sponsorship.
5. Digital Digital	• Workstream co-owned and sponsored with the Local Digital Roadmap initiative
…. Embedded within the central programme team Comms & Engagement; Change; Citizen Led	

Surrey Heartlands Academy

Vision & outcomes

The Surrey Heartlands Academy will be the enabler which will provide best evidenced, best value, excellent health and social care for the citizens of Surrey Heartlands. The Academy will:

- Act as the **collaborative mechanism** for a common, structured and consistent co-production process to service design and change
- Challenge **unwarranted variation** in practice
- **Work in close partnership** with the Clinical Senate, KSSAHSN, Citizen groups, Surrey Health Partners and the Universities;
- **Enable current, and future, pockets of innovation** developed by Surrey Heartlands clinicians to grow, drive and deliver across the Surrey Heartlands footprint to the benefit of patients.

The Surrey Heartlands Academy will be underpinned by a cycle of innovation and continuous improvement. It will develop a methodology based upon an approach of co-production amongst all Surrey Heartlands clinicians and citizens.

Assumptions

- Senior clinical/ professional staff (decision makers) will be released to become members of the Surrey Heartlands Academy Board

Rationale for change

We see **variation** in quality, pathways of care and use of system resources across our footprint and between our footprint and comparable areas. CCGs and providers have begun to address this variation in practice and outcomes via the national RightCare programme, although this work does not currently align with value based pathways. We do not yet have an **environment which is conducive to developing clinically led innovation**

- The culture of the NHS is more top down than bottom up. Front line clinical staff may not feel empowered, inspired or motivated to lead innovation.
- There are pockets of innovation and best practice of quality improvement in Surrey Heartlands but there are limited examples of where innovation has been adopted across the system.
- There are pockets of high capability in driving quality improvement taking place within separate organisations which has created pockets of excellence.
- Whilst a number of staff have been trained in improvement and RightCare methods knowledge and skills are not widespread, and there is less knowledge and skill for leading innovation.

Objectives

- **Consistent clinical standards**: defined what is right and promote adoption, sharing best practice across the clinical community
- **A systematic approach to quality and outcome monitoring**: we will move from anecdote to making decisions based on the data and fact and measure what is important to citizens
- **Clinical ownership** of the challenge of tackling variation, embedded into day to day practice
- **Empowered citizens:** use information to help citizens be better informed to make decisions about their care and take personal responsibility for their health
- **Financially sustainable pathways** enabling the work of each of our clinical programmes

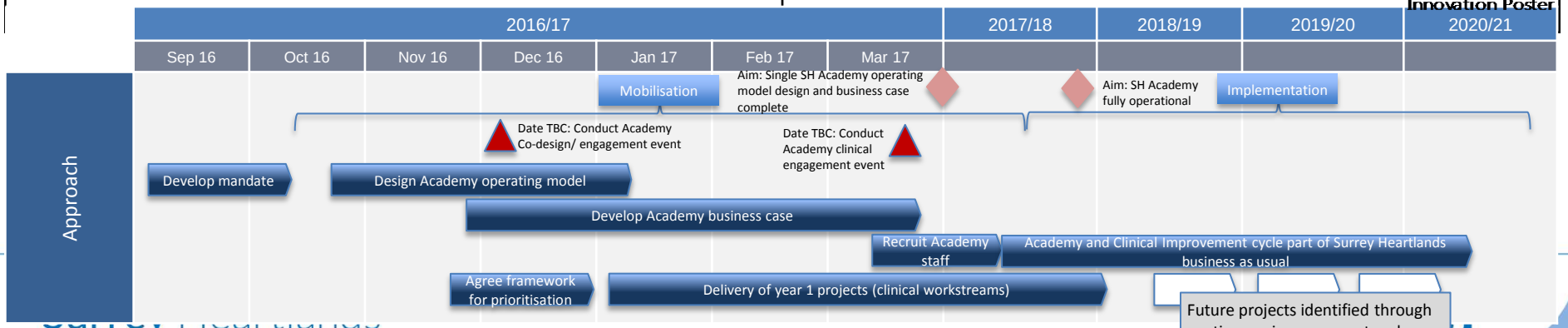
Risks/ Mitigation

- **Clinicians/ professionals oppose the development of the Academy**– Academy Board to take responsibility for driving clinical engagement across the footprint

Public Intelligence User Driven Innovation

- The embedded poster sets out the methodology we will adopt as our starting point and develop through our work with Southern Denmark

User Driven Innovation Poster



Cancer

Vision & outcomes

Our vision is to transform cancer services in Surrey Heartlands to provide the very best cancer outcomes that also address the challenges of a growing and ageing population. Where it is possible, preventing the development of cancer in the first place. Where not, enable those diagnosed with cancer to live for as long and as well as is possible (increase survival rates) regardless of their background or where they live (reduce variation geographically and socio-economically). To support this, boost early diagnosis to enable the most effective treatments to be used, and provide the highest quality care and support, including psychological support, from the moment cancer is suspected. Our overall aim is to make big improvements in cancer services, by empowering the clinicians to lead the improvement programmes and place patient outcomes and experience at the heart of cancer care.

Rationale for change

We know our survival rates are not good enough in this country, we know we can do more to improve patients' experiences and long-term quality of life, and we know that there is unwarranted variation in outcomes between different parts of the area and for those from different backgrounds.

Assumptions

- The number of people living with or beyond cancer, using national assumptions, is predicted to double by 2030
- Cancer spend likely to increase by 9% over the next 5 years in the absence of efficiency savings
- Cancer Centres will continue to work across more than one STP
- Specialised Commissioning for Cancer shifts from NHS England to CCGs enabling end to end pathway commissioning

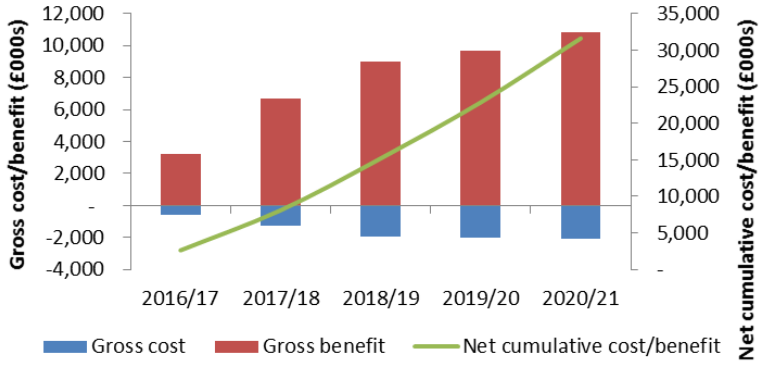
Objectives

- Help diagnose cancer earlier
- Improve patient outcomes and reduce inequalities in access to and uptake of services
- Health system sustainability and transformation
- Improve Efficiency & Productivity

Risks/ Mitigation

- **Coordination across multiple organisations becomes too difficult and stops initiatives progressing at pace** > Put in place a Programme manager to coordinate and focus efforts
- **Changes to Super Specialised services pathways are not made aware to Surrey Heartlands STP and affect finances e.g. Stereotactic RT** > Ensure communications with other STPs and NHSE Spec Commissioning

Financial impact



Roadmap

2016/17							2017/18	2018/19	2019/20	2020/21
Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17				

- Future Diagnosis & Treatment models complete
- Efficiently saving initiatives identified and quantified
- Cross-STP Spec Comm Strategic Commissioning Plan
- Pathway 'Quick Wins' delivered

Deliver Efficiency Savings & Identified Schemes

Mental Health

Vision & outcomes

A holistic, citizen led approach to promoting health, wellbeing & resilience by connecting mind & body, families & communities. Good mental health prioritised by everyone & harnessing the collective power of health, local government, social care, the community and citizens to design, extend & transform service models. To enable this we will develop a networked operating model that connects across the health and care system, embedding the principles of integrated mental & physical wellbeing and providing a seamless interface with acute and out of hospital care services. Within the new operating model we will prioritise:

- **Estates optimisation:** improving the gaps in the quality of inpatient provision and improving dignity of care whilst exploring opportunities to co-locate with other services
- **Reducing pressures on the acute system:** increased investment in Enhanced Core 24 Liaison Psychiatry Services to deliver a significant financial and quality ROI – e.g. reduced ED waiting times, admissions, re-admissions & lengths of stay & improved experience & care outcomes
- **Enhancing prevention and increasing access to early intervention** by connecting and strengthening care networks and pathways within primary care - through expanding approaches such as the team around the practice, social prescribing, IAPT and scaling the Recovery College model across the footprint

Assumptions

Increased use of early intervention and integrated mental and physical healthcare will enable reduced demand for acute services resulting in 0.2% to 0.3% reduction against 15/16 figure in each of the five years to 20/21
The capital cost of building a second hospital is est. at £100m. with some £35m. being derived from land sales.

Rationale for change

The Five Year Forward View for Mental Health makes an unarguable case for transforming mental health care and sets out national priorities There is a need to improve access to early intervention services and ensure that people complete treatment to prevent escalation of need. We need to promote the importance of good mental health to our citizens and empower people to take more control over their health needs, as set out in the 5YFV for MH. Health inequalities across our footprint result in higher pockets of mental health need within a number of our boroughs and service provision can be patchy and vary according to differing commissioning intentions, clinical views and historical service infrastructure. People who use services, carers and professionals report "gaps" in the current system:

- No managed system and too many "wrong doors"
- System not working together effectively to plan and deliver services across all sectors and providers
- Barriers to change in a complex system
- Lack of integration of mental and physical health care

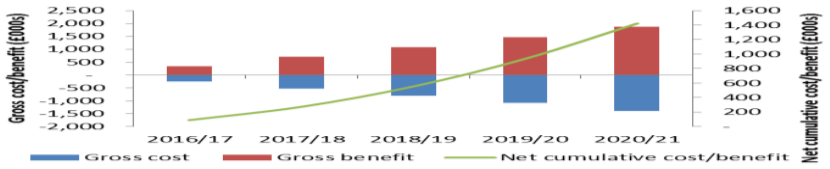
Objectives

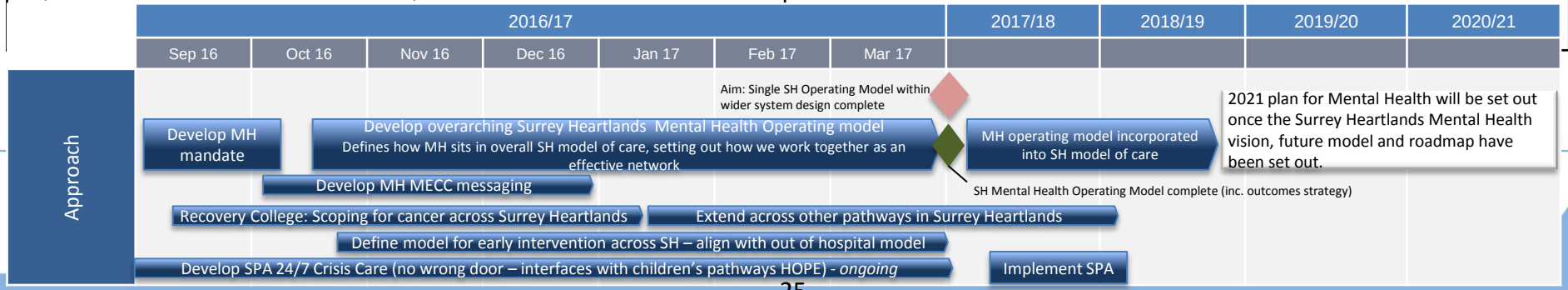
- Create resilient communities through prevention & early intervention
- Ensure the system is based on a holistic model of total wellbeing that is person and family centred
- Build broader capability & wellbeing across the system wide workforce
- Ensure delivery of a coordinated and connected system
- To measure what matters to people focused on optimising value

Risks/ Mitigation

- **Workforce – risk of inadequate numbers to deliver the specialist care required, challenges in recruitment, current siloed approach to workforce planning -** Requires new thinking as we design new and innovative roles, network expertise and cross skill
- **Estate not currently configured to best support provision of best mental health care –** work with the Estates workstream to identify changes to the use of estate to best support patients with mental health needs in our footprint

Financial impact





Women's and Children's

Vision & outcomes

We want to achieve sustainable, high quality physical and mental health care for women and children that is responsive to diverse local need and affordable. We believe we can achieve this through better integration of care across our systems. Our vision builds on good local practice and is aimed at ensuring we retain and build on a skilled and enthusiastic workforce. Whilst delivering consistent and high quality standards we will also focus on opportunities to keep services local and reducing unwarranted cost. Our vision will harness solutions to ensure effective, high quality but affordable care, including preventive factors and self-management. A key early enabler to support this vision is developing one clinical management structure across our acute obstetrics services to remove organisational boundaries whilst continuing to deliver services locally, shaped around need.

Assumptions

An integrated system approach will result in a 2-2.5% decrease in paediatric admissions/ attendances in each of the 5 years to 20/21, against 15/16 figures.

Rationale for change

- High proportion of under 4's attending A&E, low uptake of immunisations, high emergency admissions with lower respiratory tract infection. Public health challenges include the reduction of teenage pregnancies, alcohol consumption, obesity rates & smoking
- Some unwarranted variation in access and outcomes across SH
- **Workforce** - unsustainable pressures across all areas
- **Demand-** demand for urgent care & outpatients remains high
- **Safety** – combination of workforce issues and the pressure of high demand and increasing complexity has impacted upon services ability to maintain high quality and good outcomes
- ***Better Births*** - We need to respond to improvements in maternity care outlined in this national review

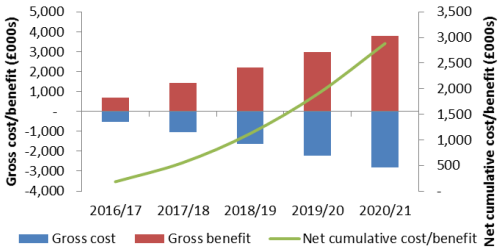
Objectives

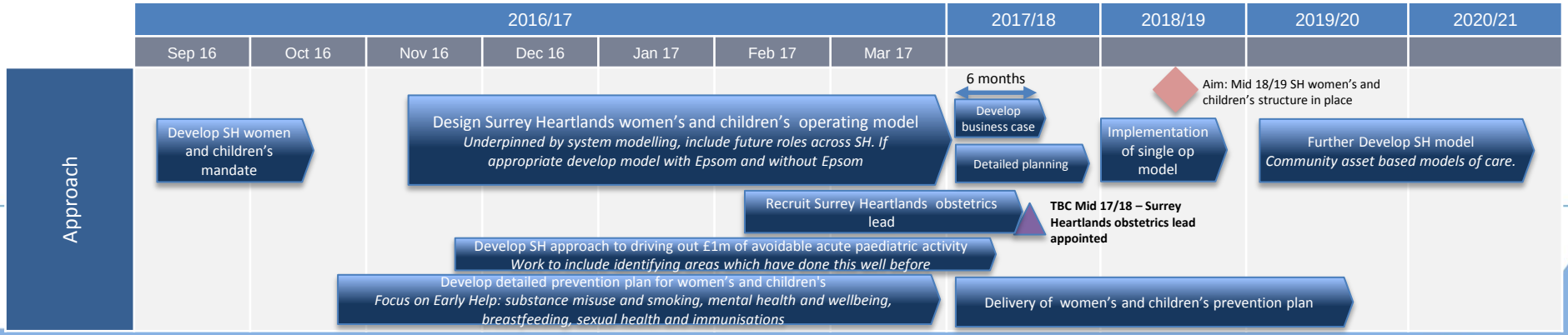
- Create one acute clinical management model for Surrey Heartlands obstetrics services
- Adopt a multi-system approach to prevention, early identification and health promotion
- Target unwarranted variation through the development of whole system pathways of care

Risks/ Mitigation

- **Clinicians resist cultural and model changes -** Effective staff engagement undertaken, clearly defining benefits and creating ownership amongst the wider team
- **Lack of multi-agency commitment to work together 'as one' -**Effective engagement with partners, share responsibility for change across SH

Financial impact





Cardiovascular

Vision & outcomes

We aim to improve control and awareness of the population's blood pressure and reduce the population risk of type 2 diabetes by developing innovative outreach methods and increasing case finding in primary care to identify at risk populations, allowing timely management in community settings (including psychological support) such as community hubs, pharmacists and GP Practices, promoting self-care and reducing the current reliance on specialist services. We will develop and operate under one Surrey Heartlands cardiovascular operating model which delivers a best in class cardiology service across the footprint.
We will agree pathways with flows to agreed accredited providers, clearly setting out 1) what sits at locality level 2) what sits at STP footprint level, and 3) what sits on a broader (cross-STP) footprint level.
We will aim to develop services within the STP footprint to re-patriate activity where possible and where appropriate

Assumptions

Increased volumes of timely management in community settings and reduced dependence on acute services:

- Decreasing the number of acute admissions due to prevention;
- Repatriation of activity, meaning providers gain additional income only partly offset by additional marginal costs

Rationale for change

Cardiovascular disease (CVD) remains a leading cause of morbidity and mortality and a significant burden to health services and the economy. In Surrey Heartlands coronary heart disease and cerebrovascular disease are the second and third largest contributors respectively to premature mortality.
2/3 of deaths could be avoided through improved prevention, earlier detection of factors such as hypertension and diabetes and better treatment in primary care.
Health and social care provision in Surrey Heartlands is stretched and is subject to increasing demand
To improve outcomes we must ensure clinical best practice is followed for CVD, hypertension and diabetes treatment, monitoring and rehabilitation

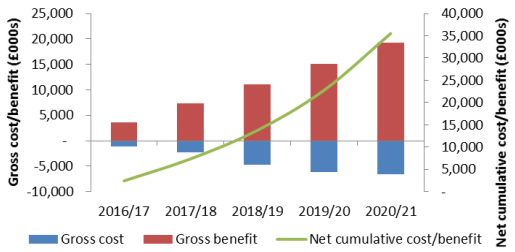
Objectives

- To improve control and awareness of the population's blood pressure
- To reduce population risk of type 2 diabetes
- To develop a Surrey Heartlands Cardiovascular Operating Model

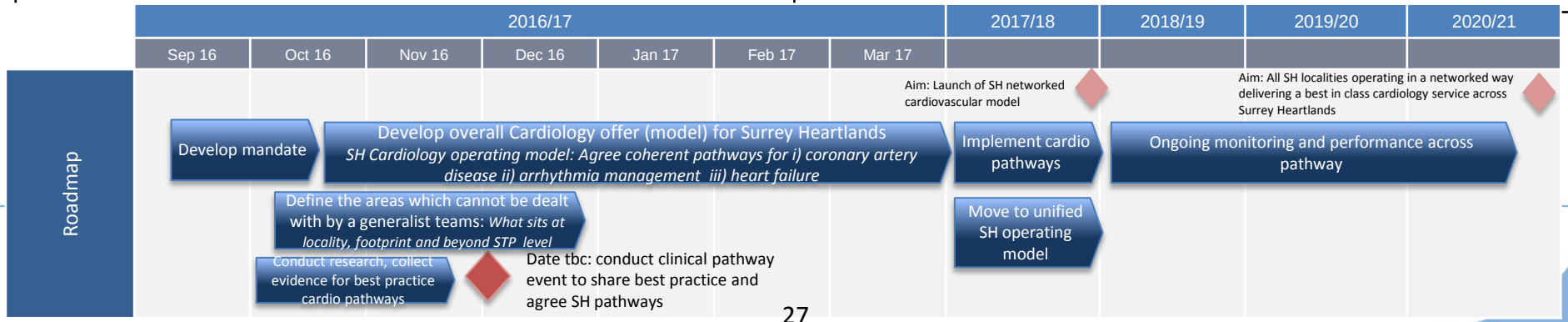
Risks/ Mitigation

- **Workforce – risk of skill shortage to deliver the specialist and community care required** - Mitigation: sharing of resources within footprint and with other out of area Providers
- **Cardiovascular model not agreed by all stakeholders** - Mitigation: joint development of the model care by all member organisations, led by an independent clinical chair, acknowledging and building on the clinical effectiveness of existing partnerships
- **Leakage of activity- Patients will have a view on the re-configuration required to deliver effective cardiovascular services-** Mitigation: early engagement with the public, keep messages simple & consistent

Financial impact



Roadmap



Musculo-skeletal

Vision & outcomes

Our vision is for a single, evidence based, best practice MSK pathway for citizens which focuses on empowering patients to self care and on prevention to ensure clinical interventions are delivered at the right time in the right setting. We will change the emphasis on the management of MSK conditions from a biomedical to a biopsychosocial approach to improve the health outcomes of our citizens who have MSK needs by providing the most efficient, effective, economic and safe treatment possible.
We will develop and implement a single MSK pathway model, adopting standard assessment and triage protocols with treatment options focused on evidence-based outcomes. The pathway will drive a shift in culture for both our citizens and clinicians by empowering patients to better manage their health and reduce the need for clinical interventions in both primary and secondary care.

Assumptions

Workstream efficiencies are predicated upon assuming Surrey Heartlands CCGs will match 2015/16 best in peer group with respect to outpatient appointments per registered 1000 patients and Outpatient to Inpatient conversion ratio

Rationale for change

- Musculo-skeletal services within Surrey Heartlands account for the largest pathway spend in the each of the constituent CCGs
- MSK services span both community and secondary care with significant operative interventions for hip and knee conditions. In addition, Surrey Heartlands has a higher than national average number of patients being admitted with femoral neck fractures
- Fracture patients have longer recovery times and longer lengths of stay when compared with peer CCGs
- This complex picture, and the ever increasing older population, is expected to result in more demand on current services if left unchecked
- Currently each CCG takes a discreet MSK pathway management approach, with broadly similar steps, but with a variation in performance across the footprint

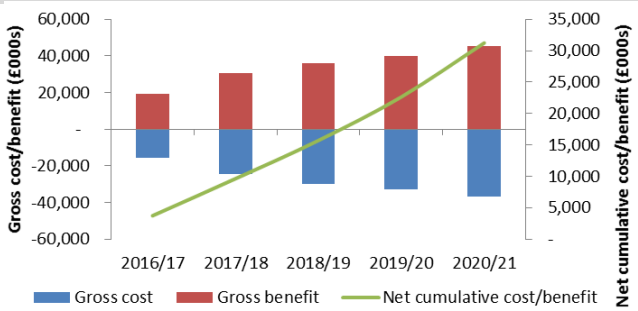
Objectives

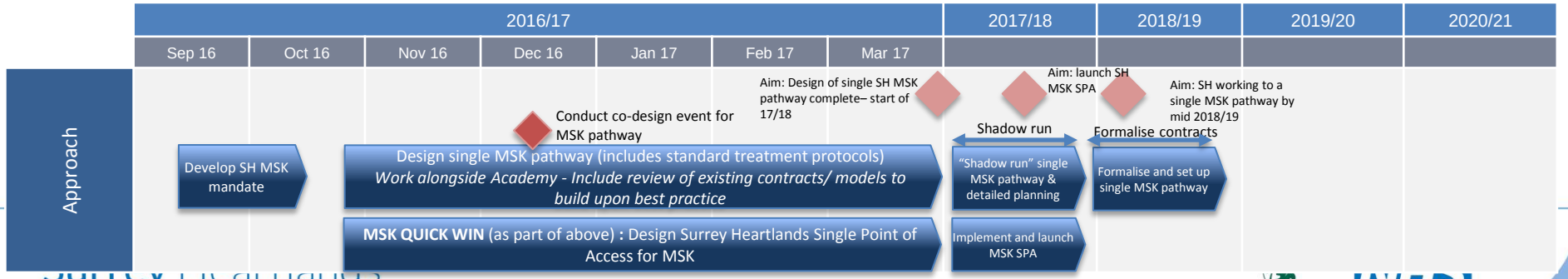
- Develop a single MSK pathway
- Improve efficiency of specialist MSK practitioners
- Reduce MSK outpatient activity
- Improve health & care outcomes for patients with MSK needs

Risks/ Mitigation

Individual CCG procurements compromise the development of a single MSK pathway – Exec Sponsor to proactively engage with respective commissioner and provider exec teams to maintain consensus in approach
Lack of community clinicians to deliver new service - Work with commissioners and community organisations to ensure they are involved in delivery of pathway
Resistance to change within secondary care – Exec Sponsor to involve clinicians from SH acute providers in design and implementation of single MSK pathway

Financial Impact





Urgent & Emergency Care

Vision & outcomes

To deliver, Safer, Faster, Better through a whole system operating model. We will provide urgent and emergency care services for people of all ages, with physical and mental health problems, improving out-of-hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions. This will mean:

- Citizens are better equipped to help themselves;
- Citizens receive right advice or treatment at first point of contact (inc. redefining OOHs & 111 service provision);
- Adults and children with **urgent** care needs will have a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families;
- Those people with more serious or life-threatening **emergency** care need will be treated in centres with the right expertise, processes and facilities, receiving a consistently high standard of care

Assumptions

- Greater use of ambulance treat services, specialist frailty units, better ties with homes, reducing demand for acute services
- This will result in 1-4% reduction in acute admissions/ attendances against 15/16 levels in the 5 years to 20/21

Rationale for change

Confusing landscape for patients with numerous access points, including 2 walk in centres, 1 minor injuries unit and 1 GP led urgent care centre and wide spread variation in pathways. Previous attempts to alter the urgent care offer across the footprint have had variable levels of success. In addition:

- Attendances and admissions in secondary care continues to rise and is not sustainable. Primary care is at capacity so new models will be required to deliver the care closer to home;
- Variation in the use of ambulatory care pathways and limited use of urgent outpatient appointment slots to prevent admissions;
- A recent stocktake undertaken by the UEC Network has demonstrated that the mix of walk in care is variable and does not meet the new standards in terms of opening hours and workforce and also the DOS (directory of services) is not utilised.

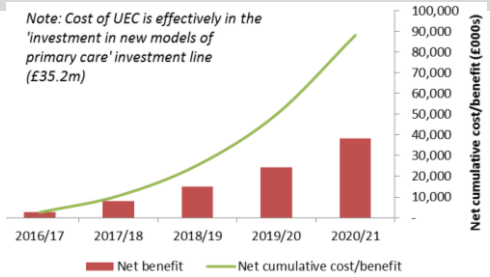
Objectives

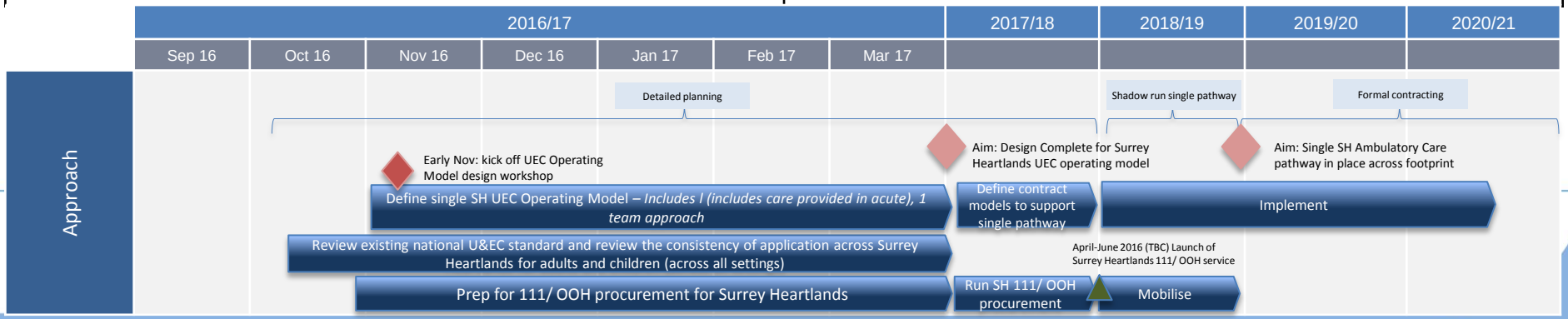
- Deliver a standardised Urgent and Emergency Care service provision across Surrey Heartlands
- Deliver a forward thinking, multi-skilled, inter-disciplinary workforce
- Deliver a single point of access for professionals to get advice
- Inform and educate the general public in the use of urgent care services and the benefit of self-care

Risks/ Mitigation

- **Clinicians resist cultural and model changes** – Clinical Lead to take responsibility for driving workstream level engagement with clinicians across the footprint
- **Lack of capital to support reconfiguration and designation** - Exec Sponsor and Strategy Lead to set out capital requirements and put forward case for support
- **Inadequate numbers of different professional staff to deliver the specialist care required and challenges in recruitment** – Develop ideal workforce model and feed into workforce workstream as input to overall SH workforce design activity

Financial Impact





Prevention

Vision & outcomes

The vision for prevention in Surrey Heartlands places preventing ill health and disability at the heart of the health system. We will drive a fundamental shift towards prevention and early intervention during the whole life. This will be through both the delivery of the prevention initiatives detailed within this workstream and by working alongside each of the clinical work streams to map and deliver opportunities to intervene upstream to improve and maintain people's physical and mental health.
The delivery of this vision will increase the number of years all Surrey residents live in good health and accelerate improvements in those currently experiencing the worst health.

Assumptions

- Planned investment needs to be made in a timely fashion or the return will be delayed beyond the period of the plan

Rationale for change

Some of the greatest improvements in health outcomes have resulted from addressing the causes of diseases rather than just treating their consequences.
Focusing on primary prevention has the potential to yield significant savings over the medium and longer-term.

Objectives

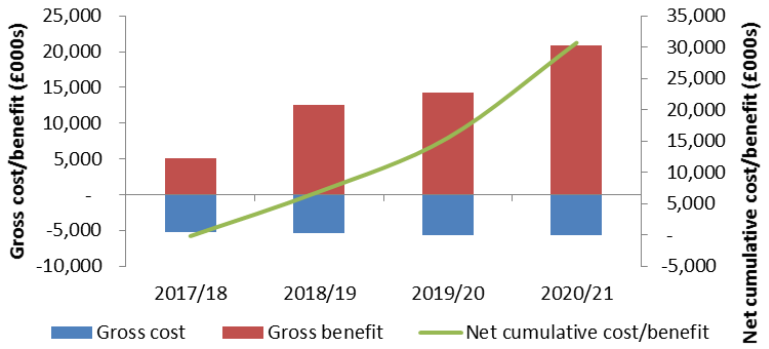
- Prevent the increase in child & adult obesity through system-wide place based and behaviour change approaches
- Prevent development of long term conditions through primary prevention programmes focussed on the major causes of ill health
- Empower citizens to remain independent in their own homes by supporting carers, strengthening social networks & the generation of social capital
- Improve health outcomes for people with long term conditions
- Improve the health of working people through the development of workplace health and wellbeing programmes

Primary and secondary prevention at the forefront of all clinical workstreams

Risks/ Mitigation

- Prevention is not fully embedded into whole system planning/resourcing > ensure prevention is seen as key enabler for each clinical workstream and central to end to end pathway design
- Whole systems budget reductions reduce capacity to realise ambitions within STP > working closely with the Transformation Board to ensure required funding is secured

Financial impact



Roadmap

2016/17							2017/18	2018/19	2019/20	2020/21
Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17				

- Prevention Lead identified for each clinical workstream
- Unified SH Prevention Plans agreed
- All STP Organisations achieved WWC
- Develop Prevention Plan Content and Rollout

Out of Hospital & Primary Care

Vision & outcomes

A model of care where each locality within the footprint manages care to a consistent set of standards and coordinates care across a consistent set of Surrey Heartlands pathways. Boundaries between settings begin to "blur" with providers spanning multiple settings. Traditional commissioner-provider model will be challenged. The new model will have generalist professionals at the heart of the system, but will see networks of doctors and hospitals coordinating care. Unnecessary spend will be eliminated and the model will be underpinned by a single system control total. Complex frail patients will be taken out of hospital settings ultimately delivering the best possible care for Surrey Heartlands patients

Assumptions

Early release of STP Transformation funding to fast-track delivery of locality models

Rationale for change

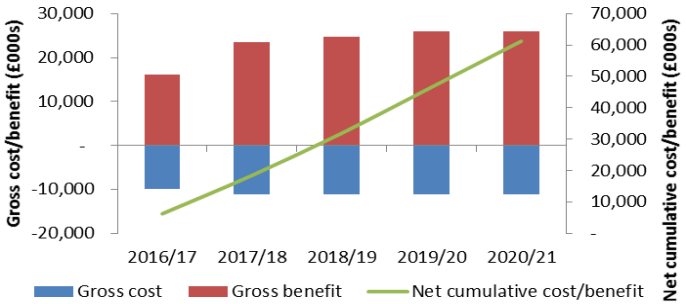
- Current fragmented primary and community care system which defaults to hospital based care, resulting in too many admissions, which last too long and result in too many handoffs and transfers of responsibility;
- Growing frail elderly population & burden of chronic disease;
- Social care cannot fund, or source provision/workforce – disparity between demand and available staffing;
- Variation in practice and lack of evidence-based care on a consistent basis;
- Increasing difficulty on delivering a way of accessing services that is relevant to all groups of citizens.

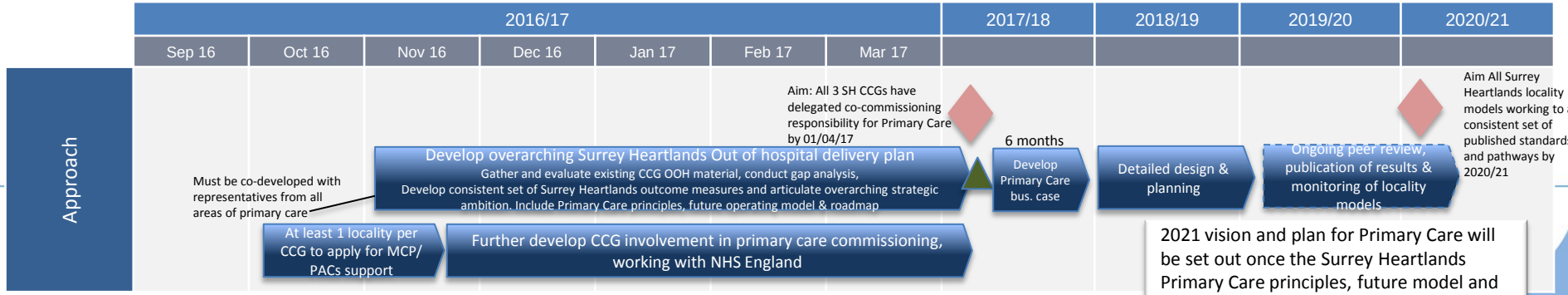
Objectives

- **Enabling people to stay well** - maximising independence and wellbeing through prevention and early intervention
- **Enabling people to stay at home or in the most appropriate setting** - integrated care delivered seven days a week through enhanced primary and community services
- **Enabling people to return home sooner from hospital** - excellent hospital care and post-hospital support for people with acute, specialist or complex needs

Risks/ Mitigation

Financial impact





Acute Operating Model

Vision

- Where patients become acutely sick and require hospital treatment, they will receive a consistently high standard of care that meets agreed quality standards and outcomes
- Providers in each of our localities will work together jointly in the interests of our patients
- We will achieve best practice through removing unwarranted variation

Assumptions

Current savings assumed from level of addressable fixed cost in inpatient specialties, with high fixed staffing requirements, currently operating over multiple sites. Quality, workforce sustainability and patient experience benefits also driving prioritisation

Rationale for change

- The ideal catchment size to support a full range of acute services is c.500,000 people.
- Acute Trusts now facing a shortage of clinical and non-clinical staff in many areas leading to high use of temporary staff and challenges in providing consultant delivered care 7 days a week
- Many services with specialised staff are duplicated on multiple sites

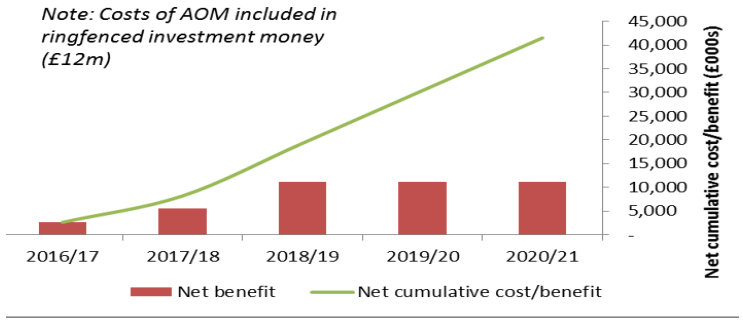
Objectives

- Establish detailed options for service reconfiguration at site level, based on current interdependencies and capacity
- Model options, assessing impact on cost base, workforce sustainability challenges, travel time, site capacity and capital requirements
- Establish governance and consultation process to consider, involve engage upon and agree options

Risks/ Mitigation

- Building clinical input to, and consensus around, potential changes – via ongoing engagement of Trust Medical Directors
- Public and patient concern about proposals – to be addressed with support of deliberative engagement process, and clear quality rationale for changes
- Uncertain capital expenditure requirements
- Uncertain Trust-level revenue impacts requiring mitigation through SCT

Financial impact



Workforce

Vision & outcomes

Surrey Heartlands will be recognised as a great place to work, where the focus is on providing quality and consistency of care across the region. There will be a shift from the current multi-organisational view of the workforce to a more unified Surrey Heartlands identity, which will be recognised as providing excellent work and living opportunities within the environment of Surrey. By creating a best in class workforce with a strong and universally recognised philosophy and culture we will be able to attract and retain the best professionals who will in turn provide the best service to our population.

Assumptions

- There is no financial benefit defined to date for the Workforce workstream – it is assumed that any financial benefit will be realised in other workstreams.

Rationale for change

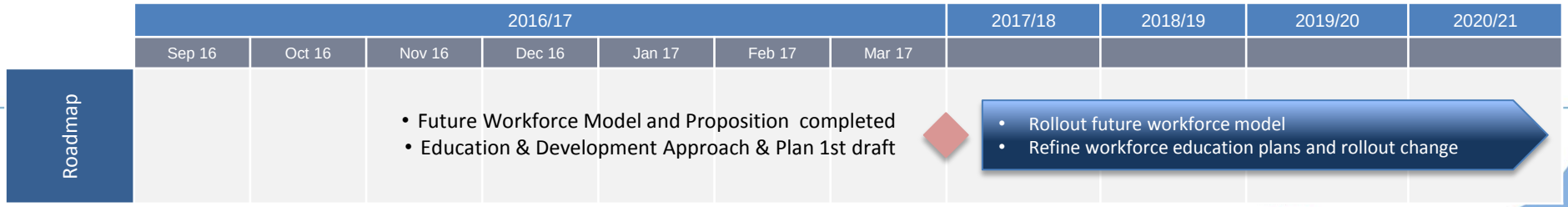
Surrey Heartlands is a new strategic planning area for workforce planning and management. Significant opportunities therefore exist to leverage the combined workforce of all eleven partner organisations to look at how we solve the current challenges as well as develop a future workforce model that operates as one integrated team to support the combined Health and Social Care agenda.

Objectives

- Address the immediate operational challenge of ensuring that sufficient staffing is provided to deliver services to the population of SH, prioritising logically across the system when it is not possible.
- Develop the 'future workforce' model for SH that centres around a 'one team' philosophy to sustainably deliver the new pathways and models of care developed by the STP.
- Involve staff in the future vision and secure commitment for the plan to achieve it collaboratively.
- Define, enable and deliver a strategy to equip the SH workforce with the necessary skills & values to enable & drive the vision.
- Promote and build the health, wellbeing and resilience of the workforce.
- Define the 'employee offer' that makes SH an attractive place to work, driving recruitment and retention.
- Create the environment and cultural conditions where everybody is a leader and advocate for Surrey Heartlands on behalf of the population.

Risks/ Mitigation

- Cultural and behavioural shift, if not done correctly will result in the workforce not engaged and bought into the transformation > adopt robust workforce engagement and change management approach



Business Support Services

Vision & outcomes

We have an ambitious plan for joined up, efficient and resilient business support services across the Surrey Heartlands system that enable high quality, safe and integrated health and social care services for our citizens. We will do this by: consolidating services where it makes sense to do so; eliminating duplication; using our collective scale and 'buying power' to get the best value; taking a commercial approach to our work and identify opportunities for income generation; working together to recruit and retain expert resource (particularly in 'difficult to recruit' functions); building resilience through access to pooled resources; providing greater opportunities for sharing learning and expertise across the footprint.

Rationale for change

As part of coming together in a 'one system' model to deliver population based Heath and Social Care models, Surrey Heartlands has an opportunity to streamline business support service functions to drive efficiencies as well as raise the quality and consistency of service delivered across the STP Footprint.

Assumptions

- Standardisation of clinical pathways, procurement and processes and the creation of centres of excellence will provide the opportunity for business support services efficiency / standardisation.
- The scale of savings will rely on the integration of some functions with single points of leadership.
- Single control total and transparency of business support service costs will be needed to deliver these objectives.
- Maximising savings will require shifts in approach and the sign-up of organisations to those shifts.
- ESHT business support functions are not within the scope of this workstream (as part of the SW London STP).

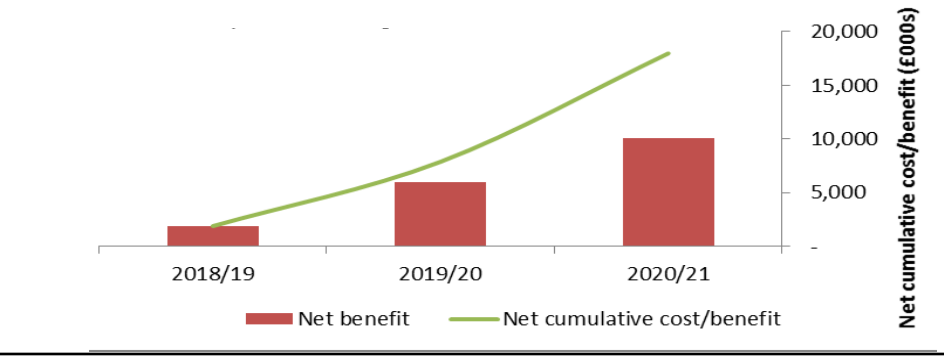
Objectives

- Reduce the cost of our business support functions
- Focus on innovation, quality & sustainability for our business support functions

Risks/ Mitigation

- Insufficient capacity to deliver change within support services impacts negatively on delivery of support services and service quality
- Inability of partners to identify and / or agree sufficiently ambitious new models of delivery leads to lower than planned savings
- Immediate/early opportunities for consolidation/efficiencies are missed due to focus on longer term / strategic changes

Financial impact



Roadmap

2016/17							2017/18	2018/19	2019/20	2020/21
Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17				

Agree Year 1 Opportunities

• Year 1 Savings Implementation

High Level Business Case

• Phased Implementation of Functional Workstreams

One Public Estate

Vision & outcomes

The vision is to achieve an integrated estates strategy and master plan that enables the Surrey Heartlands clinical strategy and which is driven by the Surrey Heartlands strategy. This will improve the efficiency & effectiveness of the estate, therefore delivering savings and revenues that can be used on front line care. We will take an outcomes focussed approach to strategic development of the Surrey Heartlands estate. The STP estate will be overseen as an integrated entity, with all estates decisions taken to align with the future priorities of the STP footprint. Capital will be recycled within the footprint and focussed on areas of Surrey Heartlands priority.

Rationale for change

There is no current integrated approach to estates strategy and very little co-operation or co-ordination on estates issues and developments between the various organisational entities across the STP footprint

Assumptions

- Revenue from building and land disposals can be released back to the footprint rather than the centre in order to support the implementation of the clinical strategy and investment in front line services.
- NHS Property Services are fully engaged in the process and support the principle of the STP having overall management / control of the estates footprint. Note – ongoing dialogue to underpin this assumption.
- A continuing collaborative approach on estates issues by estates professionals and clinicians across the STP and that legacy issues do not obstruct progress – this will include consideration of the estates and capital infrastructure for cancer as well as estates and infrastructure plans with neighbouring STPs particularly the Surrey Sussex Cancer alliance

Objectives

- Baseline the current Surrey Heartlands Estate
- Give the Surrey Heartlands STP member organisations control of the entire Estate so that it can be overseen as a single entity
- Ensure clinical necessities and public engagement is sought and incorporated into the Estates Master Plan
- Develop and deliver an Estates Master Plan that enables the other STP workstreams and supports the system as a whole

Risks/ Mitigation

- **Surrey Heartlands can't keep the revenue generated as a result of asset disposals within the footprint** > clarity is sought regarding national strategy on estates receipts

Financial Impact

* One Public Estate efficiencies will be attributed to the Business Support Services workstream

	2016/17							2017/18	2018/19	2019/20	2020/21
	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17				
Roadmap	Agree opportunities and validate existing individual organisational estate plans in light of STP principles					As is Estate Audit & To Be Estates Model complete			Master Plan complete and To Be Estates Model revised		
									• Deliver against Future Estates Model Master Plan		

Digital

Vision & outcomes

Surrey Heartlands will utilise digital technologies as enablers to compliment existing practices of physical, social and mental health care delivery. Additionally, through embracing open innovation methodologies we will seek to define new ways of delivering services by using and developing technologies that are appropriate to need . Experience based co-design will enable Surrey citizens to meaningfully engage with digital solutions as we strive to promote more autonomy and our citizens taking great responsibility for their own wellbeing.

Rationale for change

Leveraging the work completed to date as part of the Surrey Local Digital Roadmap (LDR), the Digital work stream sets out how the LDR will be aligned and incorporated into the STP to deliver the critical STP digital enablers.

Assumptions

- Partner organisations agree on a single digital strategy and roadmap across Surrey Heartlands
- Citizens and care professionals agree to a common information consent model
- Unless there is a clear Digital cost benefit, financial benefits will be realised in those work streams that Digital is enabling

Objectives

- Establish an integrated digital health & care record
- Deploy a Professional Carer portal
- Deploy a Citizen portal
- Using technology to shift care closer to home and into the home
- Provision population health analytics
- Optimising clinical systems
- Deliver paper free at the point-of-care capabilities
- Deliver enabling technologies

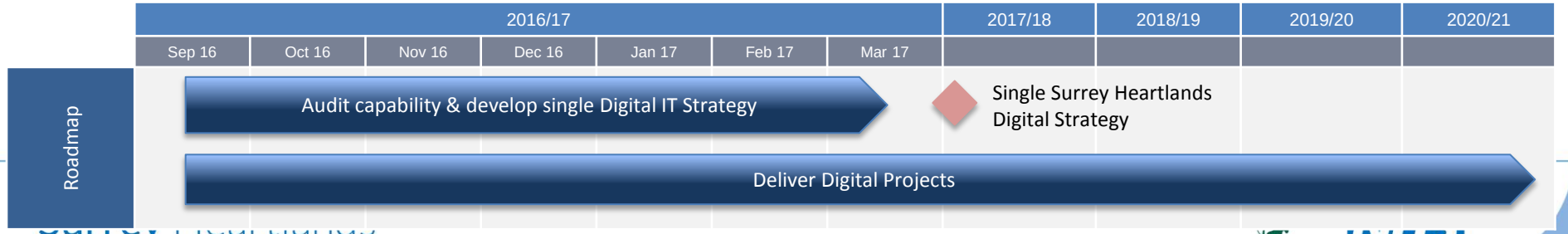
Risks/ Mitigation

- Good change management to transform the organisations is critical in realising the desired outcomes > adopt robust workforce engagement and change management approach
- Suppliers do not have the sufficient capacity to meet the demands of all STP/LDRs in the timeframes required > continue to develop relationships with suppliers, make them aware of our plans, place orders early where possible; and monitor.

Financial impact

The Surrey Heartlands Digital Roadmap will require significant capital investment over the next 5 years. The investment profile is set out below:

2016/17	2017/18	2018/19	2019/20	2020/21	2016 - 2021
3.7	7.1	6.4	4.7	0.2	22.1



Citizen-led and Comms & Engagement

Vision & outcomes

Our ambition is to embed a robust citizen-led approach across Surrey Heartlands. This will help us have a better understanding of the informed opinions of local residents we engage with. They will be better equipped to take part in co-designing services and understand the role they can play in taking personal responsibility for their health. The workforce (including CCG membership) across health and social care will be truly engaged in a consistent way across Surrey Heartlands, with them understanding, shaping, owning and adopting the change. Effective communications and wider engagement will underpin the citizen-led, workforce engagement and change approach.

Rationale for change

Effective and co-ordinated engagement, supported by robust communications, is vital to the success of our Surrey Heartlands STP and local delivery of the NHS Five Year Forward View. Given the scale of the challenge and change required, we want to put the citizen at the heart of what we do and embed a new citizen-led approach that forms the foundation of all our work across Surrey Heartlands.

Assumptions

Resource from across all partner organisations (both health and local authority) will support the key activities of the workstream, which will be central to the overall STP programme.

Objectives

- To define & embed a new citizen-led approach across Surrey Heartlands
- To ensure the workforce are truly engaged and understand, shape, own and adopt the change
- To ensure effective communications & engagement, including the public, wider workforce, other stakeholders & media

Risks/ Mitigation

Whilst supportive of a citizen-led approach, patient representatives have asked how meaningful this can be given the fast pace of the programme. This has helped reaffirm the importance of conducting the deliberative research and conjoint analysis at the outset, which is now underway. Experience across Surrey with prior transformations, dictates that a collaborative, respectful approach to engagement and communication is required to bring about what are likely to be significant changes to the health and social care system for service users and their carers.