NHS
Surrey Heath
Clinical Commissioning Group

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DELIVERING THE FORWARD VIEW
PLANNING FOR 2017/2019

OPERATIONAL PLAN
Executive summary

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1. Introduction

This Operational Plan is our route map for how Surrey Heath CCG (the CCG) and its partners make a reality of the NHS Five Year Forward View[1] (FYFV) within the resources available to the NHS. It builds on the successful changes implemented in 2016-17 and is set firmly within the context of the Frimley Health and Care Sustainability and Transformation Plan (Frimley STP).

It is a public document which aims to provide assurance to our Governing Body and NHS England and to inform our local stakeholders of our current position, our plans and next steps.

There has been a strong focus throughout this year's planning process to ensure that sufficient activity has been commissioned to give confidence to our community that NHS commitments within its Constitution, such as waiting times for A&E, surgery and cancer care, will be met. Equally the CCG has been working with providers and our social care colleagues to build sufficient capacity in both our community and hospitals to meet planned demand.

The document covers the challenges we anticipate in 2017-19 and how we will meet them, a high level summary of the key components of our plans, their planning footprint/geography, and the governance arrangements put in place to align system wide commissioner and provider plans.

Our commissioning intentions relate to the whole of our community and cover children, young people, working age and older adults and will address the needs of both patients and their carers.

Our local system goes into 2017-18 in a good position having delivered in 2016-17:

- A high quality service across its providers with a strong performance on NHS Constitutional requirements including in-year improvements in managing A&E performance and diagnostic waits.
- All its statutory financial obligations.
- Continued improvements in quality and safety.
- Marked step forward in integrative working across all community partners, including general practice and social care, with 8am – 8pm established as routine working hours (Monday to Friday) and some 7 day services available to all
- Joint commissioning with social care becoming a reality with the contractual formalisation of new working relationships
- A population that consistently rates the quality of their health services highly.
- Benchmarked key stakeholder data that ranks the CCG's partnership working above the national average across all indicators

[1] NHS Five Year Forward View NHS England November 2014

- Staff satisfaction survey (Picker Institute) rating the CCG as an employer that is significantly better than average across all staff engagement metrics
- Strong system relationships and collective leadership competencies
- A greater focus on workforce redesign and staff development within the CCG and provider organisations
- A transformational momentum with many of the key foundations in place to ensure system sustainability

2. Our 2017/19 Challenge

Delivering high quality health and social care within the resources available has never been a greater challenge for the NHS and its local authority colleagues and this financial pressure is significant in our locality.

In health, the CCG faces a “do nothing” funding gap of approximately 7% (£8m) of its budget in 17-18 and 18-19. This is significantly beyond the value of any savings delivered locally to date.

The scale of the increase in the financial challenge has been caused by a number of factors:

- Activity growth in both emergency care and the number of operations being undertaken, influenced by an ageing population and increase in public expectations.
- Non-recurrent monies (one off funding) not being available in 2017-18 and beyond
- All transformational resources coming from within CCG allocations. Despite strong bids the CCG has received no additional NHS investment through New Models of Care Vanguard Programmes or GP Transformation Funding but has made significant investment in both areas itself.
- Non delivery of planned activity reductions in our hospital contract despite community investment which, although managed in 2016-17, create a financial and operational risk for the system in 2017-18
- Continued risk around specialist commissioning and CCG allocations.

Continuing to improve quality and deliver on Constitutional Standards will become more demanding for our local system within this financial context. It will require a detailed focus from the CCG to maintain 2016-17 improvements and proactively manage in 2017-18 any signs of deterioration with the early instigation of recovery plans. The main areas of performance concern going into the year are A&E performance, rising waiting lists for operations and ambulance response times.

However, the most significant challenge for the CCG is the question of how to build on the momentum already in place and realise the benefits of community investments and the strong clinical relationships between these services and the hospital to change patient flows.

A “home first” approach means that our plan promises to better support more people in their own home wherever appropriate. A focus on reducing the harm of unnecessary interventions or surgery and commissioning activities that add the most value to individuals and the population are complex and challenging concepts to explain to people and clinicians in order to get buy-in.

Delivering the **right care**, in the **right place** at the **right value** is our 2017-19 Operating Plan challenge.

As a CCG we focused in 2016-17 on delivering the building blocks of its community sustainability and county footprint strategies including:

- Enhancing the impact of our community based Integrated Care Teams by working more closely with the hospital at the interface between community and hospital services
- Empowering community staff to drive forward the “home first” approach and build on the momentum of the first year of integrated care
- Reducing inequalities by commissioning general practice at scale through locally commissioned services
- Putting prevention and self-care at the heart of “whole place” commissioning
- Working more closely with our member practices (GP) to involve them in initiatives to improve quality and safety
- Improving access and responsiveness for families and children and young people with mental health issues
- Targeting resources for patient transport to those with greatest need
- Piloting hospital outreach services to support long term conditions management
- Enhancing clinical support to nursing homes through a multi-disciplinary approach (GP, community matron, medicines management and dietetics)
- Strengthening and formalising the commitment of the CCG and county council to testing what can be achieved through full integration between health and social care for adults in Surrey Heath.

2017-19 will see a much greater requirement to realise the benefits of additional out of hospital funding in community services. In order to maintain the high quality services currently experienced by our population and achieve a balanced financial position the local system will need to:

- Reduce demand on acute services – both emergency and planned activity
- Ensure hospital capacity is used appropriately with people returned to the community for support at the earliest possible stage, eliminating avoidable admissions, interventions and days in hospital that have low clinical value and hence low value for money.
- Utilise the full capacity and competencies of the community workforce, statutory and independent care providers
- Establish more robust mechanisms for the sharing of clinical risk and information between hospital and community providers
- Engage and develop communities and individuals to play their part in supporting people to be well

Time and capacity will need to be found to ensure attention is still given to make certain patient safety and the quality of care is maintained, and improved, throughout the drive for change at pace. All parts of the system will need the space to think differently to radically transform our commissioning and provider landscape and our own staff will require support and development to meet the challenges of a shifting commissioner and provider landscape.

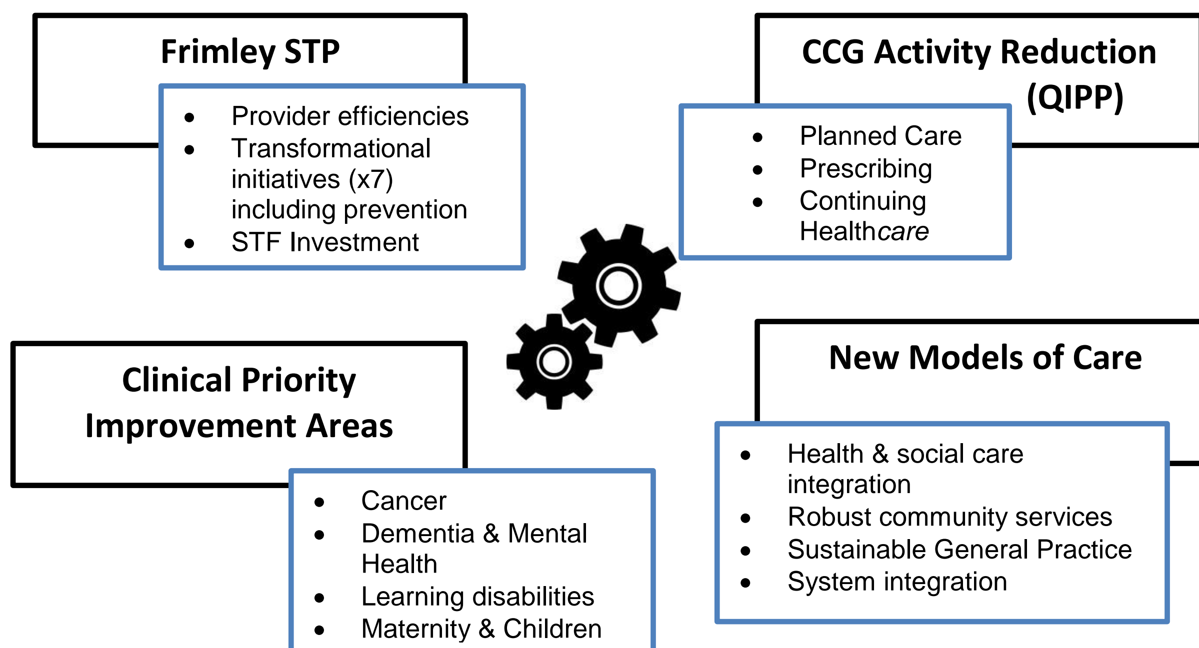
3. Our Approach to Meeting the Challenge

Our 2017-19 Operating Plan can be grouped into four areas. All are critical cogs in the delivery of our plan. All have to be delivered in partnership.

The shared vision and coherent set of activities developed as part of the Frimley STP are a core component of our 2017-19 plan and accounts for 80% of our financial savings in 2017-18.

Success will depend on connecting the strong system leadership skills within the STP with the energies of clinicians, patients, carers, citizens and local community partners, to engage in new conversations and joint actions. The new conversations and joint planning required to develop the STP plan have been critical in delivering an operational plan that is owned by both commissioner and providers across health and local authorities.

The STP priorities initiatives on their own are not enough to close the financial and wellbeing gaps within our local system and additional CCG activity reduction plans (QIPP) and a focus on key clinical areas for quality improvement will be required.



Whilst these improvements are being made the model of out of hospital services need to be enhanced to complement the historical investment in hospital services locally.

The FYFV introduced the public to the need for New Models of Care:

"The traditional divide between primary care, community services, and hospitals, largely unaltered since the birth of the NHS, is increasingly a barrier to the personalised and coordinated health services patients need."

It particularly emphasised:

- Out of hospital care being a much bigger part of what the NHS does
- Services needing to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time
- A requirement to expand and strengthen primary care

This Operating Plan signals a fundamental change in the expected care model for our local community by the end of 2018-19. The new accountable care system would include a fully integrated health and social care approach for community services across commissioning and provision. The primary care plan will build a sustainable clinical, business and career model for general practice that will integrate with other out of hospital care providers. The new model will fully involve people in the planning and delivery of care to meet the personal goals and outcomes they have set in partnership with service providers.

Surrey Heath CCG enters this planning period with confidence and a focused determination to deliver the changes required as it faces the demands ahead. This confidence is based on knowledge that we start from strong foundations of health and social care excellence and have a track record, built over the last two years, of brave, bold, collaborative transformation.

The Frimley STP offers additional scale and pace to the transformation required and a framework for whole system decision making that has not previously been available. Together we can meet the challenge of delivering core access and quality standards, improvements in health and care and maintain system wide financial balance.

4. Our Plan

4.1 Delivery Priorities

Our commissioning intentions and local delivery objectives have been influenced by a number of different sources that set local priorities within the framework of the FYFV.

SOURCES	LOCAL HIGHLIGHTS
STP gaps analysis, Right Care and STP priority initiatives	o Good baseline position with: o Growing & ageing population & demand growth projecting to outstrip resources o Main contributors to lives lost: circulation, cancer, respiratory, trauma and musculo-skeletal o Other contributing areas: diabetes, dementia, psychosis, common mental health disorders, maternity & early years o Unnecessary emergency admissions for conditions that could be managed in the community o People spending too long in hospital o Right care quality & cost gaps: circulatory disease, cancer, respiratory, trauma & musculo-skeletal o Recruitment and retention challenges particularly in the support workforce o Market forces driving up the bed based care and domiciliary prices to health and social care
Quantitative needs & asset assessment data including our local Joint Strategic Needs Assessment (JSNA) & Surrey Heath Health Profile	o Rapidly ageing population with a subsequent increase in members of our community with one or more long term condition and an ageing cohort of carers requiring support. o Scope to reduce risk factors to healthy lives e.g. smoking, diet, alcohol & impact on Potential Years of Life Lost (PYLL) o Geographical inequalities especially the Old Dean estate (falling life expectancy) o More potential to support & develop community assets (friends, families and communities)
Qualitative assessment of need through feedback from our community, patients, providers and member practices	o Focus on prevention particularly in the young o Early signs of improved access to mental health services children and young people following the recent CAMHS procurement o Opportunities to improve access to general practice o Concerns around GP workforce sustainability o Simplify pathway for people moving between health and social care o Improve NHS 111 quality and signposting o Enhance nursing home care provision o Home based care packages (access and quality)

SOURCES	LOCAL HIGHLIGHTS
Surrey Health and Wellbeing Strategy	○ Improving children's health ○ Developing a preventative approach ○ Promoting emotional wellbeing and mental health ○ Improving older adults' health and wellbeing ○ Safeguarding our population
Clinical Priority areas (IAF benchmarking & 9 must dos in FYFV)	Cancer: ○ Targeted approach for early diagnosis, smoking cessation, screening. ○ Interface between cancer centre and cancer unit to improve 62 day waits ○ Focus on follow up care & life after cancer Diabetes ○ Improve blood pressure monitoring & reduce variation in care pathways between practices ○ Improve access, uptake and recording of structured education programme ○ Targeted approach to healthy weight management & diabetes prevention ○ Establish multi-disciplinary foot teams ○ Build on specialist input into care Learning Disabilities ○ Ensure all people with LD are on practice registers ○ Develop all age support team for individuals with challenging behaviours ○ Reduce mortality gap Maternity ○ Encourage participation in maternity services audits to increase sample size ○ Share learning on still birth mortality learning across two Frimley Health Foundation Trust sites ○ Implementing Better Births maternity plan Mental Health ○ Improve usage of Recovery College ○ Introduce mental health practitioners in GP surgeries ○ Increase access to psychological therapies for those with long term conditions ○ Improve access to specialist perinatal mental health care ○ Understand better local suicide rates & services ○ Eliminate Out of Area Treatments (OATs) by 2020 ○ Implement single point of access for crisis services ○ Improve domiciliary care support for people with mental health and/or behavioural issues

SOURCES	LOCAL HIGHLIGHTS
Current performance An assessment of the strengths and weaknesses of our local services and the identification of any gaps	o Ambulance response times o A&E 4 hour target o Growing elective waiting lists o Mental health access times & specifically access to psychological therapies (IAPTS) o Opportunity to improve “home first” offering to prevent admission and reduce discharge delays o Delays in commencing care packages and placements for people with dementia and behavioural issues o GP referral increase and secondary care intervention thresholds for some specialities (Right Care)
A review of National planning guidance and expectations (Five Year Forward View)	o Prevention o Empower patients & engage with communities o Co-create new models of care o Primary care as central & with potential new models o Implementation of urgent and emergency care review o Improve quality & outcomes o Improve patient safety o Meet NHS Constitutional standards o Achieve parity for mental health o Transform care for people with learning disabilities o Enable change through technology, innovation and workforce
Business opportunities & efficiencies	Procurement o NHS 111 & GP OOH o Community physiotherapy, community pain & MSK Business Models o Place based funding and workforce structure with social care “one place one budget one team” o Current underutilisation of innovative contractual and pricing structures o Opportunity for greater information sharing & interoperability o Greater estates optimisation across health and social care o Running cost efficiencies across health and social care locally

4.2. Key Commissioning Intentions and Delivery Objectives

The intelligence gathered from the sources above has resulted in the following seven key commissioning intentions for 2017-19.

- A focus on prevention and self- care
- “Home first” approach reducing reliance on bed based care
- Commissioning for value
- Improve access, outcomes and services to children and young people
- Provide a functionally integrated 24/7 urgent care service
- Deliver a fully integrated model of care for health and social care
- Develop a sustainable clinical, career and business model for general practice

It should be noted that intentions apply to all ages including children and families and that specific attention will be paid to groups that face potential health inequalities due to deprivation or access to health services.

1. A focus on prevention and self-care with delivery and further development of the Surrey Heath Health and Wellbeing Plan and maximising opportunities for delivery at scale and shared learning within the STP (Priority Initiative 1)

Delivery Objectives: Priority areas have been identified in the plan in the following areas: reduced prevalence of long term conditions through action on their leading causes, stepped approach through universal to targeted, specialist support of tackle the leading causes of circulatory disease, cancer, respiratory disease and diabetes, improve the health and wellbeing of children and young people with a focus on healthy weight and emotional wellbeing, improving the workforce and helping people to live independently in their own homes, reducing social isolation and non-elective admissions to hospital. Each priority has its own set of activities, lead, timescales and key performance indicators. (KPIs)

Vision for the end of 2018-19: Local commissioners across health and social care will be continuing to develop and will be regularly monitoring a jointly agreed prevention plan and set of long term metrics that will lead to evidence of reduced health inequalities in our community. By the end of 2019 the resources collectively spent on local Surrey Heath prevention activities across the county council, borough council and CCG will be transparent and conversations will have taken place around opportunities to achieve greater value from these investments through collaborative working and potential budgetary devolvement. Prioritisation based on existing inequalities will be more apparent. Any opportunities for added value at an STP footprint will have been identified and delivered. Digital solutions will form a much greater role in supporting healthy lifestyles.

Footprint: Strong STP engagement with joint local delivery.

Leadership Organisations: STP partners, SHCCG, Surrey County Council including Public Health, Surrey Heath Borough Council, Voluntary organisations

Governance:
STP Priority 1 Steering Group & Surrey Heath Alliance
Surrey Health and Wellbeing Board (operational planning & delivery)
Local system reporting through to STP plan.

Linked projects/plans: Very strong interface between STP & local plans. Prevention and self-care programme for QIPP. Dependencies with STP GP transformation plan, workforce strategies & digital roadmap**.**

2. Move unplanned care activity towards a more planned care approach by supporting people in their own home, promoting independence and reducing the reliance on crisis management and bed based care. "Home first approach."

There is a strong interface with STP Priority initiatives around integrated decision making hubs (Initiative 2), general practice transformation (3), support workforce redesign and availability (4) and implementing a shared care record (7)

These initiatives also form part of the Frimley South A&E Delivery Board's admission avoidance plans and will be instrumental in reducing pressure on Frimley Park Hospital's A&E Department and reliance on bed based care.

Delivery Objectives: The key metric is to reduce the number of avoidable admissions to hospital or residential/nursing home bed based care with a focus on the frail elderly, those with mental health issues and learning disabilities. The number of people dying in their preferred place of death will also be increased and delayed transfers of care reduced. The A&E target will be achieved at Frimley Park Hospital (and across Frimley Health FT) with greater ease as lower rates of admissions reduce pressure on the discharges required to improve the flow through A&E. Winter system resilience will continue to improve.

Early diagnosis and improved access to mental health services will be established. The local community responds more positively to those with mental health issues, dementia and learning disability due to campaigns to reduce stigma and create dementia friendly communities. Single point of access for crisis support will be implemented. As commissioners we habitually consider population mental health alongside physical health.

The Surrey Transforming Care Strategy for people with learning disabilities and autism will be implemented.

Vision for the end of 2018-19

(a) **Frail Elderly**: A radical shift in the number of emergency admissions to Frimley Park Hospital will have taken place compared to 2016-17 and a reduction in usage of care home bed based care. This will be achieved through benefits delivered by the establishment of integrated community teams of health and social care staff working alongside general practice, a strengthening of personal care plans (including personal health budgets), proactive management based on having a diagnosis of frailty, and improved responsiveness at "crisis" points. Improved co-ordination of care and support will be reported by patients and their carers and care homes. Approaches to rehabilitation and reablement will be co-ordinated through a single intermediate care team. There will no longer be gaps in the capacity to deliver domiciliary based personal care and rehabilitation. Patients with long term conditions will be identified early and appropriately supported in the community by their GP working in partnership with the practice multi-disciplinary team (MDT) and consultant specialists. Thresholds for admission will increase following discussions and agreement between GPs and consultants as greater confidence in community services is developed and shared risk management processes are established.

Footprint: Surrey Heath delivery footprint with shared learning across STP and Frimley South A&E Delivery Board

Leadership Organisations: SHCCG, Surrey Heath Borough Council, Virgin Care, Surrey County Council, Surrey and Borders Partnership NHS FT, general practice, voluntary sector, Frimley Health NHS FT. STP partners

Governance:
Surrey Heath Alliance: strategy.
Surrey Heath Integrated Care Steering Group: Operational delivery.
Surrey Heath Joint Commissioning Group (social care integration)
STP Steering Groups (initiatives 2, 3, 4, 7).
Frimley South A&E Delivery Board.

Linked QIPP Projects/Plans: Integrated Care Teams including Intermediate Care, Care Homes, Frailty project, Community in-reach and hospital interface, Cancer & End of Life Care, Continuing Healthcare, Falls, Nutrition, Medicines Optimisation/polypharmacy, Dementia. Prevention Plan. Primary Care Plan. A&E Delivery Board Urgent and Emergency care plan.

(b) **Mental Health**: Full delivery of the Crisis Concordat actions including establishing a Single Point of Access for Mental Health Crisis integrated with 111/999 and smooth pathways with Safe Havens, Home Treatment Team's and Intensive Support Teams (ISTs) and improved psychiatric liaison for adults and children.

Footprint: Surrey and Local Mental Health Collaborative (SHCCG & North East Hamphshire and Farnham CCCG)

Leadership Organisations: CCGs, Surrey County Council, Police, Fire Service, Surrey and Borders Partnership NHS FT, ambulance service, voluntary sector providers (Catalyst and others) acute hospitals, community providers & GPs.

Governance: Surrey Health and Wellbeing Board with local feed into Frimley South A&E Delivery Board and commissioning structures.

Linked QIPP Projects/Plans: Crisis pathway. Enhanced access to psychological support for those with long term conditions. Recovery College.

(c) **Learning Disabilities**: Full implementation of the 2017-19 actions for Transforming Care including supporting people who currently live in hospital to live in settled homes in the community and ensuring people with learning disabilities are identified by their GP and receive a health check. Implementation of mortality reduction plan to close the gap in life expectancy between the general population and those with learning disabilities

Footprint: Surrey and joint (health and social care) local delivery at a SH footprint.

Leadership Organisations: Strong County leadership role with local delivery.

Governance: Surrey Heath Local Joint Delivery Board & Surrey Health and Wellbeing Board with local feed into Surrey Health and Wellbeing Board Learning Disabilities Partnership.

Linked QIPP Projects/ Plans: Surrey Heath Learning Disabilities Strategy (in progress) Transforming Care local plan. Prevention Plan. Primary Care Plan.

3. "Commission for value" ensuring we drive improvements in the provision of high quality and efficient care and through this approach develop a shared vision for acute services within a system wide sustainability model

Strong interface with STP initiative "Reducing Clinical Variation" (Number 6)

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Delivery Objectives: The aim will be to use the principles of Right Care[2] to develop a shared system wide vision for sustainable acute care, delivering an agreed demand and capacity model for elective care which is jointly owned. This will include reductions in clinical variation of elective referrals (general practice) and interventions (secondary care) in line with best practice nationally across the Frimley STP. Outcomes to include improved quality, better population level health, a reduction in inequalities, "right sized" elective capacity and better value for the taxpayer. The STP will have a focused programme based on an assessment of opportunities identified through analysis of Value based commissioning data. In addition there will be some locally targeted areas specific to Surrey Heath.

[2] For further information on Right Care www.england.nhs.uk/rightcare/programme

Vision for the end of 2018-19: A whole health economy targeted on delivering the value opportunities that exists locally by focusing on those areas where we are an outlier compared to nationally benchmarked data.

A clearer vision of how general practice decision making and acute provision form part of system wide sustainability approaches

Footprint: Largely STP with some specific local initiatives.

Leadership Organisations: 5 CCGs, Frimley Health NHS FT, GPs, specialist commissioners (NHSE)

Governance:
STP Clinical Variation Steering Group
CCG GP Steering Group
Frimley South Editorial Board (Elective Care Board)

Linked projects/plans: Respiratory, MSK, Neurology, Circulation, genito-urinary, referral management, procedures of limited clinical value, medicines management

4. Improve access, outcomes and services to children and young people with both community and mental wellbeing needs

Delivery Objectives:

Commission high quality, cost-effective services for children and young people that maximise efficiency and synergy between health and social care and community, acute and primary care services.

Realise the benefits of a significant additional local investment in mental health services for children and young people as part of the Child and Adolescent Mental Health Services (CAMHS) re-procurement.

Re-procure during 2016-17 an integrated Surrey wide community service for children and young people to start from 1st April 2017.

Vision for the end of 2018-19:

Transition to new CAMHS services have been delivered smoothly and with clear signs of improvements in patient and family experience of care.

Realigning children's community health services across the county into one contract will have improved our ability to integrate service delivery across and within partner organisations; for example across early years, education and social care, with core health services providing seamless care to families using common standards, aims and outcome measures.

Improve the services for looked after children and those with special educational needs ensuring children with behavioural difficulties are well supported.

Footprint: Surrey with some local interfaces

Leadership Organisations: 6 Surrey CCGs, Surrey CC, NHSE, Public Health, Community providers, Surrey and Borders NHS FT

Governance:
Children: Children and Young People's Partnership Board a sub group of Surrey Health and Wellbeing Board (HWBB). Children's Commissioning Group.

Linked Projects/Plans: CAMHS, access to psychological therapies, peri-natal health, community services re-procurement, "Right Care" for children, acute disinvestment (community paediatrics). Maternity Services Review – Better Births and Saving Babies Lives delivery plans.

5. Develop a specification and procurement schedule that will deliver a functionally integrated 24/7 urgent care service acting as the front door to NHS treatment and advice.

Delivery Objectives:

Deliver the benefits set out in the Urgent and Emergency Care Review[3] led by Sir Bruce Keogh and reflected in the Commissioning Standards for Urgent Care[4] through a functionally integrated 24/7 urgent care service which includes: community services, ambulance services, emergency departments, social care, NHS 111 and general practice (in hours and out of hours).

Vision for the end of 2018-19

New services are better signposted and support more self-care options. People with urgent care needs get the right advice, in the right place, first time. New NHS 111 services, clinical hubs and access to GP urgent advice 24/7 means that people no longer choose A&E as responsive alternatives are available. More appropriate use is made of emergency services which supports the achievement of 999 ambulance response times.

Footprints, Leadership and Governance: Will be confirmed following procurement footprint decisions currently within a Surrey NHS 111 procurement footprint but exploring joining Hampshire and a SHCCG/NEHF CCG footprint for GP out of hours (OOH) and Clinical Hubs but exploring option of STP wide footprint.

Linked Projects & Plans: NHS 111 and GP OOH re-procurements, Surrey Heath Care System, Mental Health Crisis, Primary Care Plan. Thames Valley and Hampshire procurements.

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[3] High quality care for all, now and for future generations: transforming urgent and emergency care in England. June 2013 NHS England

[4] Commissioning Standards. Integrated Urgent Care. September 2015. NHS England.

6. Deliver a fully integrated model of care for health and social care with our community covering both integrated provision and commissioning (Surrey Heath Accountable Care Model)

Vision for the end of 2018-19: Deliver a co-designed model that delivers our vision of "Whole person Whole Place" based care and enables people to only have to tell their story once to service providers in the community that has the following underpinning principles:

- **Enabling people to stay well** - Maximising independence and wellbeing through transformed prevention and early intervention for people at risk of being unable to manage their health and social care needs. No door is the wrong door: people will experience an integrated approach to enhance and promote their independence, choice and control and be supported to maximise the quality of their health and wellbeing
- **Enabling people to stay at home** - Integrated care delivered through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care.
- **Enabling people to return home sooner from hospital** - Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.

Benefits would include:

- Reduced duplication in care
- Greater co-ordination and collective responsibility for care services
- Empower greater clinical and professional decision making
- Increase in the consistency of standards of care
- More effective integrated workforce planning to reduce silos
- Collective solutions to system wide problems
- Improve local community and business investment opportunities
- Mitigating workforce risks by making Surrey Heath an attractive place to work and will support the recruitment and retention of high quality, motivated staff
- Formal alignment of health and social care strategies for improving efficiencies and delivering value for money

Footprint: Surrey Heath

Leadership Organisations: SHCCG, Virgin Care, Surrey County Council, Surrey heath Borough Council, Surrey and Borders NHS FT, general practice, voluntary sector, Frimley Health NHS FT.

Governance: Whole system: Surrey Heath Alliance. Health and Social Care Integration: Local Joint Commissioning Group

Linked Projects/Plans: Integrated Care Service, GP Federation, adult community services, 24/7 urgent care programme, friends/family and community development, personal care, prevention, acute outreach. Surrey Better Care Fund projects. NEHF Vanguard Project and Accountable Care Organisation aspirations.

7. Develop a sustainable clinical, career and business model for general practice in line with the FYFV for General Practice.

Strong interface with STP GP Transformation Initiative (3) and transformational enablers around workforce, estate and technology.

Delivery Objectives:

Vision for the end of 2018-19:

General practice will be at the heart of a vibrant community service infrastructure supported by specialist clinical services provided by the hospital. A sustainable model for general practice will be in place that is delivering improved access and outcomes for our patients by reducing variation in care, offering an enhanced urgent care access 7 days a week, making full use of competencies within the practice multi-disciplinary team, recruiting and retaining high quality GPs by offering portfolio career options, improved use of technology and IT and care provided at scale, when appropriate, through better use of general practice estate for clinical services.

Footprint: Surrey Heath (in hours), larger footprint to cover extended hours

Leadership Organisations: SHCCG, GP Federation including local practices and NHS England.

Governance: GP Steering Group and SHCCG Governing Body
NHSE Assurance Process

Linked projects/plans: Primary Care Plan, Estates plan, Interoperability Plan. Urgent Care Strategy (NHS 111 & GP OOH procurements)

4.3 Activity and Financial Framework

One of the key emphases in delivering the Five Year Forward View is the alignment and focus on ensuring that commissioners set realistic contracts with its providers. Matching demand and capacity will be key to ensuring delivery. As a system it is a priority to embrace the learning on demand and capacity modelling to enable us to set realistic contracts for 2017-18 and beyond. Working at STP system level this is an area of focus.

The key financial requirements for 2017-18 centre on:

- Ensuring all NHS organisations operate in recurrent balance working with the provider sector to ensure long term sustainability
- The CCG planning to deliver in year financial balance
- Retaining the cumulative 1% surplus on income and expenditure built up in previous years
- Creating1% non-recurrent headroom, of which 0.5% can be committed at the start of the year. The remaining 0.5% must remain uncommitted
- Minimum of 0.5% being held by the CCG as a contingency
- Provider Trusts developing plans to identify a minimum recurrent Cash Releasing Efficiency Saving (CRES) of at least 2% in line with tariff
- Alignment between activity and financial plans to support delivery NHS Constitutional standards and other key metrics

In its initial financial submission, the CCG met all the key financial requirements detailed above. However, as the CCG share of funding as laid out in the STP is not now likely to materialise, the financial plan has been revised.

Surrey Heath CCG's revenue allocation comprises 2 elements:

(a) Commissioning allocation: The total commissioning allocation for Surrey Heath CCG in 2017-18 is £115.36m and for 2018-19 £117.65m
(b) Running cost allocation of £1.98m for 2017-18 reducing marginally the next year and adjusted for recurrent allocation changes amounting to £42k in 2016-17

Making a total CCG allocation of £117.385m for 2017-18. This represents a 2.0% increase over 2016-17.

In addition to the allocations notified, the CCG is anticipating the return of its planned 1% surplus of £1.1m achieved in 2016-17 which is expected to be spent non- recurrently in year.

The national assumption is that the CCGs should retain its 1% cumulative surplus in 2017-18. The CCG has managed to balance its position for the last four years. Achieving a balance between a realistic level of QIPP versus required investments is challenging for 2017-18 and was dependent on the outcome of the sign off of the STP funding requirements and contract negotiations particularly with our largest acute provider Frimley Health.

The likelihood of receiving STP funding is now low and the CCG has had to refocus its efforts to identify QIPP opportunities and look at options for risk mitigation to support the overall position. In the past the CCG has mitigated a significant part of its financial risk with Frimley Health by agreeing contract caps at the start of the year. In 2017-18, the CCG has agreed a contract where risk is shared 50/50 above an agreed value.

The new ways of working around the STP place a different emphasis on the relationship between commissioners and providers and how the system operates to achieve a balanced plan at a total level. In order to meet the national business rules with all the demands on for growth, parity of esteem, and reserves, the CCG

was looking to the STP for funding of £4.4m in 2017-18 to support its overall position, rising to £5.6m in 2018-19. As this is no longer available the CCG is facing a serious shortfall in its plan for 2017-18 which is discussed in more detail below.

Our budget for 2017-18 is summarised below and includes the following growth assumptions used in both the STP and Operating Plan under "do nothing" and "do something scenarios".

Growth Assumptions

	2017-18	2018-19	2017-18	2018-19
	"Do Nothing"		"Do something"	
Demographic	0.70%	0.70%	0.70%	0.70%
Acute Growth (under "do Nothing")				
Outpatients	4.10%	3.90%	1.30%	0.90%
Elective	2.30%	2.20%	0.70%	0.60%
Non elective	2.40%	2.10%	1.00%	0.70%
A&E	2.40%	2.20%	1.00%	0.70%

Budget Summary: Programme costs only – excluding Running Costs

	2017-18 £m	2018-19 £m
Programme Funding Allocation	**115.9**	**118.2**
Acute services		
Frimley Health	55.0	56.3
Royal Surrey	2.6	2.4
Surrey Ambulance (999)	3.0	3.0
Other	5.8	5.0
Mental Health & Learning Disabilities	9.1	9.6
Community services	9.7	9.9
Continuing Care	9.9	9.9
Better Care Fund	5.5	5.6
Other Programme	(3.1)	(2.1)
Primary Care		
Prescribing	13.3	13.7
Other	3.3	3.1
1% non-recurrent reserves	1.2	1.2
0.5% contingency	0.6	0.6
Total Planned Expenditure	**115.9**	**118.2**

4.4. High Level QIPP Summary

Having taken all the assumptions as detailed above into account and with STP support no longer being available as had previously been assumed, the CCG is now planning for a gross QIPP requirement in 2017-18 of £8.2m and in 2018-19 £7.8m. QIPP plans have been developed totalling £4.2m in 2017-18 and £2.2m in 2018-19, leaving unidentified QIPP of £4m and £5.6m each year respectively. This has been shown as a risk in the plan, with mitigations identified to date of £1.9m in 2017-18 and £1.2m in 2018-19, with unmitigated risk of £2.3m in 2017-18 and £4.4m in 2018-19 remaining

Our QIPP plan for the period 2017-19 has built on work in previous years as well as opportunities identified within a CCG or STP footprint and in line with the Five Year Forward View. The work streams are therefore split between transformational STP initiatives and CCG level activity reductions.

Transformational STP Initiatives

There are 7 initiatives agreed for 2017-18 in the Frimley STP, of these 4 will impact on activity and therefore result in financial savings. These can be found in more detail in the Frimley Health and Care System STP. The 4 initiatives are:

- Prevention and Self-Care
- Integrated Care
- Social Care Support
- Reducing Clinical Variation

The STP initiatives will impact non-elective and elective activity currently in the acute hospitals and adult social care spend. Some efficiency in staffing are expected with redesigned roles, reduced duplication and a reduction on agency spend.

CCG Activity Reduction (QIPP)

The QIPP schemes to be implemented that will impact on a CGG level are grouped into the following areas:

- Planned Care
- Mental Health
- Prescribing
- Continuing Health Care

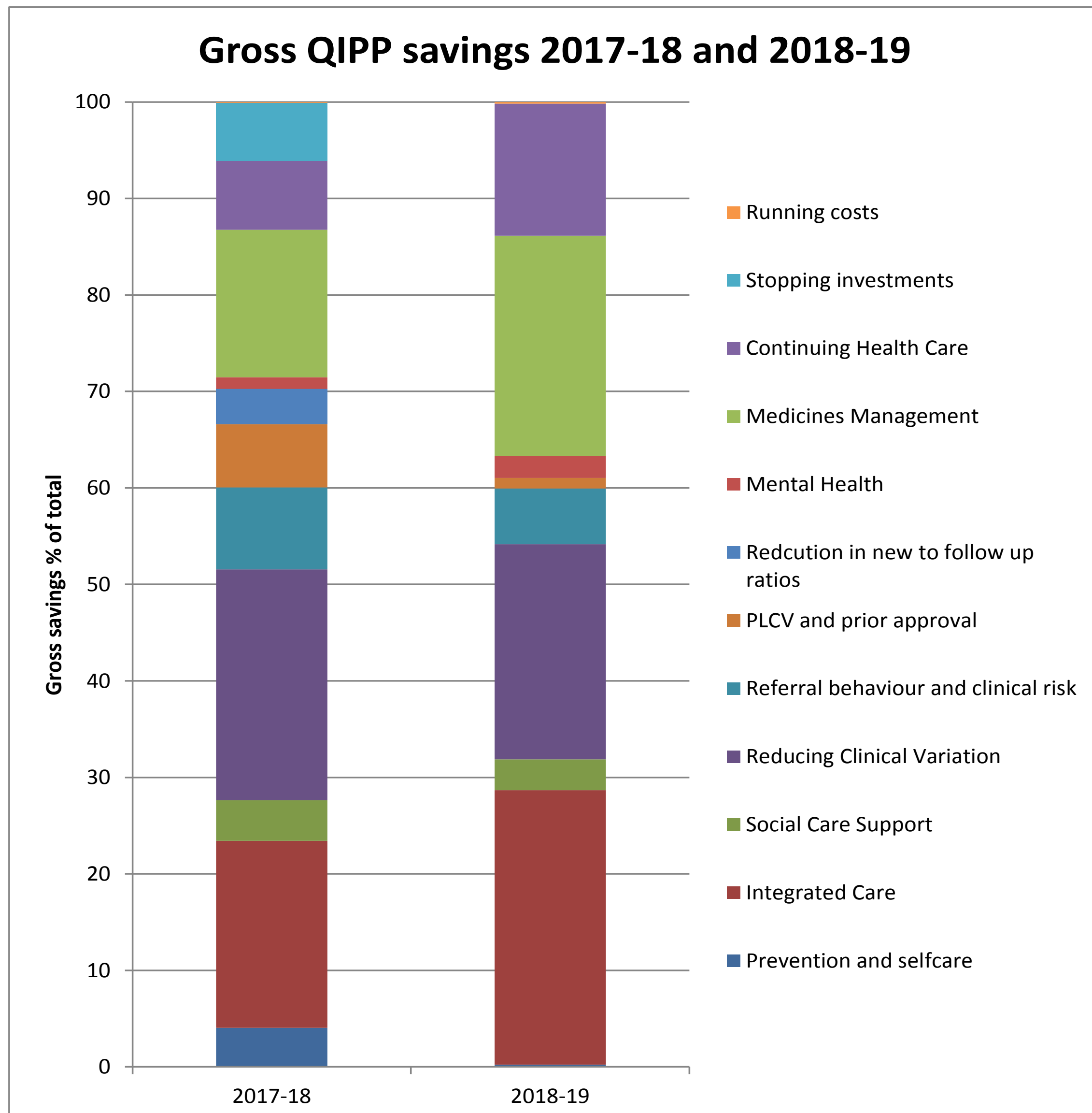
The activity and financial benefits have been worked up for each project to realistically reflect the expected project start dates and activity change expectations. As we progress through the contract negotiations and project planning we will develop and agree a clear phasing for the activity and financial savings.

In the financial year 2017-18:

- 52% of the expected efficiency savings are associated with the STP initiatives
- 48% with CCG level activity reductions
- Of these QIPP efficiency savings around 70% affects our main acute provider Frimley Health NHS Foundation Trust
- Changes are largely due to a reduction in the flow of emergency admissions and the impact of Reducing Variation/Right Care initiatives
- The other significant contribution to savings comes from the prescribing budget and our medicines management team are now integral into our project planning.

The table below indicates the main areas where savings will be achieved, for 2017-18 and 2018-19, both through the STP initiatives and from projects initiated by the CCG (savings shown gross i.e. before investments):-

In 2017-18 investments required to deliver the QIPP plan total £388k and in 2018-19, £166km, resulting in net savings of £3,809k in 2017-18 and £2,025k in 2018-19.



CCG's confidence around QIPP delivery is influenced by an increased focus on evidence based planning and that many of the projects have the operational foundations in place (year 2 of project plans) and can now focus on realising financial savings.

4.5 System Alignment

4.5.1 Level of Planning Alignment with Acute Provider

Relationships between the CCG, acute co-commissioners and Frimley Health FT have continued to strengthen at all levels throughout 2016-17 and these relationships will be critical as we jointly implement the STP and our local vision for the Surrey Heath population.

The Frimley Health FT financial values have now been agreed and built into the financial plan.

The CCG supported an expression of interest to NHSE with regard to STP shared control totals. The application submitted described how the STP would look to "shadow run" shared control totals so enable organisations to see the impact and ensure that appropriate systems and controls are developed and in place prior to an expected go live of shared control totals in 2018-19.

2017-18 will also need to work through the synergies and differences between local systems New Models of Care with the North East Hants and Farnham Vanguard favouring a vertically integrated approach (PACS) encompassing Frimley Health FT, whereas the CCG model has as its primary focus on a community based out of hospital model of care (horizontal integration).

The CCGs facing Frimley Health FT are working collaboratively through various forums including the STP Leaders Reference Group, STP Delivery Steering Groups, the local A&E Delivery Boards and the Joint Commissioning Forum to ensure delivery of strategic change.

Actions to Mitigate Misalignment

The CCG has been working throughout 2016-17 as part of a whole Frimley system group of 6 commissioners (Frimley STP health commissioners plus Chiltern CCG) using a single Joint Commissioning Forum and executive level meetings with Frimley Health FT to ensure that the Trust has a complete picture (system view) of the planning assumptions being made and to improve a wider system approach

- **Care closer to home**: Frimley Health are fully supporting of the principle of care closer to home and have championed the Surrey Heath approach to extended GP routine care (8-8) and local decision making hubs (integrated care teams) across the STP footprint.
- **Enhancing emergency demand and capacity management:** The system has enhanced its predictive model for emergency admissions (demand) and operational capacity in conjunction with emergency and planned care intensive support teams using system resilience investment money. A single system of data collection and review has been implemented across both sites, ALAMAC. The A&E Delivery Board structure is helping to focus all partners on reducing demand on Frimley Hospital's A&E Department.
- **STP: Developing a shared vision for acute sustainability within a systems wide approach:** work undertaken in 2016-17 should ensure that in future contract negotiations our shared vision for sustainability makes activity misalignments less likely. The 2017-18 contract round will test this assumption.

4.5.2 Project Alignment: STP and Local Initiatives

Whilst delivering change as part of a system wide approach offers greater opportunities for transformation, learning, pace and scale it also add complexities and a greater number of interdependencies.

Strong programme management structures have been put in place at STP and CCG level through programme management offices (PMOs), programme managers and administrative support. At an Executive level oversight within the CCG for planning and delivery across the STP and within the CCG sits with the Director of Planning and Delivery.

Delivery in both areas is required to meet the challenges outlined in this plan.