Joint Commissioning Intentions 2018/19

Engagement Outcome Report and Commissioner Responses

April 2018

Surrey Heartlands Clinical Commissioning Groups and Surrey County Council

Contents

1. Background

As part of the annual commissioning cycle, every year Clinical Commissioning Groups (CCGs) review their plans and develop what is known as their commissioning intentions for the following year. These intentions are essentially the CCGs plans and priorities for the following year and take into account national NHS planning guidance (national priorities and national targets that need to be delivered locally by CCGs), local priorities (to meet the needs of the local population) and shared plans that are being developed across a wider area (such as through the Surrey Heartlands Health and Care Partnership).

As part of our planning, every year we seek the views of local people, partners and key stakeholders on our draft plans and priorities. The aim is to ensure local people and key stakeholders are aware of our proposed plans and that they have an opportunity to provide feedback, particularly in relation to whether the plans we have set out are supported, whether they have any views on our plans and priorities and how we implement them locally and if there are any areas or issues they feel have not been addressed through our draft plans.

In previous years the three Surrey Heartlands CCGs (Guildford and Waverley, North West Surrey and Surrey Downs CCGs) have undertaken this engagement process locally. However, following the appointment of a joint leadership team across the three CCGs and the closer working that is now happening across the organisations as a result of this, it was agreed that a joint approach across all three CCGs would be beneficial, with our plans aligned for 2018/19.

To reflect plans for closer integration of health and social care services, Surrey County Council have also worked in partnership with us to share their priorities in relation to adult social care, children's services and public health. Bringing together the joint plans for health and social care services has enabled local people and partners to have a full overview of these plans and how these different areas come together. It has also meant an opportunity for people to share their views on the full range of health and social care plans once, as opposed to being asked to comment on plans by individual organisations.

2. Our engagement objectives and approach

As part of our engagement, we had several objectives:

- To raise awareness of our draft plans and priorities for 2018/19 among key stakeholders and local communities
- To raise awareness of the opportunity for local people and partners to give their feedback on our plans
- To encourage people to comment on our draft plans and priorities through an online survey or through face-to-face engagement
- To engage key partners and stakeholders through direct communications to encourage them to comment on our draft plans and priorities

- To maximise engagement opportunities with partners and the voluntary sector through face-to-face engagement to seek more detailed, qualitative feedback on our plans.

2.1 Methodology

The methodology we used to achieve these objectives included a combination of both quantitative and qualitative engagement methods.

Our engagement period ran for just over 4 weeks (from 17 January to 18 February 2018) and included an online survey (hosted by Surrey County Council on their website as part of a 'Surrey says' portal which is used for online engagement), complemented by face-to-face engagement with community groups. A summary Commissioning Intentions document was developed, which provided a short summary of our proposed plans to support our engagement.

2.2 Online survey

Working with colleagues from the Surrey County Council research team, the online survey was developed as a 'chapter-based' approach, with each chapter focusing on a different area of commissioning (such as mental health and well-being, children's services, urgent care and then local CCG commissioning plans where these have been developed locally to meet local health needs).

Given the many different areas of commissioning covered by both CCGs and Surrey County Council, the advantage of this approach was that respondents could choose which chapters they responded to and not feel they had to complete the whole survey. Some people may have felt that this would have been too much of a time commitment so this approach aimed to ensure maximum engagement levels, with respondents focusing on the areas that were most important to them.

The survey asked respondents the extent to which they agreed with a number of statements for each chapter and this format was consistent throughout. Respondents could select an answer ranging from 'strongly agree' to 'strongly disagree'.

The questions were as follows:

To what extent do you agree or disagree with the following statements:

- These plans will meet the needs of the local population
- These plans will meet the needs of me and my family
- These plans are comprehensive
- Do you have any specific comments about the plans for [add service area] we have described in the document? Do you feel anything is missing? If so, please provide details (free text box for response)

2.3 Printed materials

Printed copies of the survey, and the accompanying summary document, were also distributed to local community locations including libraries and day centres, with freepost envelopes, for those who may not have access to the internet or would prefer to complete a hard copy of the survey. Printed copies were also available on request by email, phone and SMS message for those with hearing impairments.

2.4 Face-to-face engagement

Being mindful of the limitations of quantitative engagement methodologies, which do not necessarily allow for richer feedback, our approach also included direct communications to key stakeholders and face-to-face discussions with 18 local groups and community networks, targeting specific groups to engage on key chapters such as mental health and well-being, carers and disability. This included face-to-face dialogue with the following groups:

- Guildford and Waverley CCG Patient Participation Group Chairs Network
- Guildford and Waverley CCG Patient and Public Engagement Group
- CCG staff briefings (x3)
- CCG Governing Body meetings in public (x3)
- Guildford Borough Council Health Inequalities Meeting
  Healthwatch Surrey
- Spelthorne Stronger Safer Partnership Board
- North West Surrey Patient Participation Group
- North Surrey Disability Action Network
- Parkinson's Society Group
- Guildford First Consortium meeting
- South West Surrey Valuing People Group
- Action for Carers Epsom (mental health and well-being carers group)
- Longmead Social Centre, Banstead
- Mary Frances Trust Advisory Group
  Ashtead Learning Difficulties Group
- South West Disability Alliance Network
- Surrey Downs Participation Action Network
- Banstead Day Centre Older People's Group
  Action for Carers Elmbridge, Mental Health and Well-being Carers Group

2.5 Engagement channels

We raised awareness of the opportunity for local people and partners to have their say on the draft proposals through a range of communication and engagement channels including:

- **Discussions with community groups and existing networks** (including those named above but also mentioning the engagement at other meetings and encouraging people to take part)

- **Direct email communications** to over 700 key stakeholders (including councillors, MPs, faith groups, local councils, hospices, healthcare providers, patient participation groups and voluntary and community sector organisations) to encourage them to provide feedback on our plans
- **Website banners and web pages** on all three CCG websites and the Surrey County Council website to raise awareness and encourage people to take part
- **Media release** to the local media, encouraging people to have their say
- **Social media** (including Facebook and twitter posts) by all four organisations to encourage followers to give their views
- **Engagement with key groups and networks** to ask them to share information with their members (including Healthwatch, Surrey Coalition etc) and to ask for information to be added to newsletters and community websites
- **Online survey**, where people could give their views
- **Printed materials** and copies of the survey in community locations
- **Face-to-face engagement** with specific community groups

3. Summary of feedback

The engagement process resulted in 150 people giving their views through the survey (including both online and freepost responses). Respondents chose the sections they wished to answer so the response levels for individual questions were significantly lower.

Following detailed analysis of both the quantitative (survey) and qualitative (face to face) data collected, this chapter summarises the themes from engagement by subject or commissioning area.

We have also included a commissioner response which responds to the main areas of feedback provided and our plans to address these areas.

3.1 Urgent and emergency care

Of the 79 people who completed the questions on the plans for urgent and emergency care, half (41) tended to agree or strongly agreed they would meet local need. Just under half agreed they were comprehensive (32) and would meet personal need (35).

Detailed feedback relating to urgent and emergency care commissioning plans across Surrey Heartlands highlighted a number of key themes:

- The need to have available and promote alternatives to A&E such as walk-in centres or urgent care centres to help ensure that A&E is protected from non-urgent requests. This was felt to be especially the case for people with mental health issues where other services could offer much more effective support and should be more easily accessible. All centres should be accessible to people with different communication needs.
- There was support for more effective discharge processes that may help to reduce workload on urgent and emergency care, with mention of patients being discharged into unsafe situations and readmitted on a regular basis. For this to

happen there was support for adult social care to work in conjunction with NHS services with proper funding.

- There was concern that current resources are insufficient and that logistical issues e.g. cross-border issues are hindering the ambulance and emergency services and that the plans do not effectively capture the extent of the current situation. Alongside this there was support for a better system for handing over from ambulance to A&E needed and for paramedics to have access to written records.
- There was support for extending GP opening times and making sure that different healthcare professionals in primary care (e.g. nurse consultants) are able to treat patients effectively to prevent conditions becoming emergencies
- There was support for integrating NHS 111 with GP out of hours' services to prevent multiple identical conversations and to ensure that limited resources are used appropriately. There were also requests for NHS 111 call handlers to be experienced and as a complimentary service, for NHS 111 and 999 to be able to carry out triage by text rather than voice, as this could be more efficient.

"Local practices should be encouraged to offer surgery based clinical assessments (collaboratively) - from 6 to 10pm 7 days a week for their own practice populations - this would decrease A&E visits, increase clinical accuracy and reduce access times."

"There is a need to have available and promote alternatives to A&E such as walk-in centres or urgent care centres to help ensure that A&E is protected from non-urgent requests."

Commissioner Response

The CCGs across Surrey Heartlands are committed to delivering on the Urgent and Emergency Care Five Year Forward View. Part of this is to develop Urgent Treatment Centres resulting in a 'simpler' system that we are all able to navigate far more easily as patients.

Improving patients' experience of discharge will be part of the Intermediate Care Service re-design. Patients readmitted with 24hrs of discharge are closely monitored, investigated and any learning is then reflected back to the system and teams involved so that services can improve discharge experience and outcomes.

All A&E departments have clinical pathways and business continuity plans in place in relation to service delivery. In respect of individual patients, should 'emergency medication' be clinically required then this will be provided with the appropriate patient advice and guidance by the GP.

The re-procurement of an integrated urgent care service, combining NHS 111 with the primary care out-of-hours service, aims to enhance the efficient use of resources and introduce innovative systems to optimise patient experience and produce high quality outcomes.

3.2 Children and young people

Of the 68 people who completed the questions on services for children and young people, just over a third (26) tended to agree or strongly agreed the plans would meet local need. Under half (17) agreed the plans were comprehensive or meet personal needs (only 10).

Detailed comments relating to children and young people's services highlighted a number of themes:

- A need to improve or increase access to mental health services for young people
- Some concerns around service funding and whether this is sufficient
- Greater collaborative working between health, social care, education and different agencies
- A need for further information and greater detail on services in this area and what is commissioned and why these have been selected as the key priorities
- Some concerns about the quality of some services, staffing levels and out of area transfers where services are not available locally
- Clearer links between perinatal mental health and children's services, given the link between the two
- Clearer links between other areas of work such as drug and alcohol and wider mental health
- Greater monitoring around the impact of interventions to inform commissioning plans
- The need for a greater focus on Special Educational Needs and Disabilities (SEND)
- Further work to support safeguarding and identifying those who are vulnerable earlier
- Further work to educate children in life skills

"I would particularly like specific actions to improve, and monitor the outcome of interventions put in place to improve mental health services for children and young people"

"If you can bring SEND services up to a decent standard that will be a minor miracle, but a lot of resources will be needed. There is no clear guidance or access to help or advocates in Health for CYP who have disabilities, even those who are LAC for respite purposes."

Commissioner Response

We value the comments and feedback that people have taken the time to submit in response to the commissioning intentions engagement. The feedback will be used to inform the more detailed consultations that the council will carry out should the intentions mean that there will be any significant changes to services.

We will continue our focus on improving access to mental health services for children and young people, working collaboratively across agencies. There will be further development of outcomes monitoring and reporting by the service providers. Work has started on a detailed review of current staffing levels and future workforce development, to be completed over summer 2018.

During the coming year, we will increase our provision of CYP Havens to four, across Surrey, linked to other crisis services, as well as continuing our preventative support and early intervention work in schools and other settings. We are providing additional investment through NHS CAMHS Transformation funding.

SABP are set to take on delegated commissioning of Tier 4 (in-patient) CAMHS from autumn 2018, giving greater local control and oversight.

Children's commissioners are fully engaged with counterparts in adult mental health in seeking to develop perinatal mental health services in Surrey Heartlands.

Commissioners across health, education and social care remain committed to addressing the main challenges within the SEND system which include making sure the right support to children and young people are provided at the right time and deliver the right outcomes based on their personal needs.

We will continue to engage with children and young people with SEND by working with the Rights and Participation Team for CAMHS and SEND. The team aims to ensure children and young people have an integrated voice in the services that affect them, and at all levels of those services, including initiating and developing change. As well as provide support children and young people to facilitate service user led projects that ultimately improves the user experience.

We will continue to work with children, young people and parents and providers through our SEND 2020 programme. Our shared objectives are to: transform the customer experience; rebuild the system around the customer; reshape the SEND local offer and develop inclusive practice.

3.3 Continuing healthcare

Of the 64 people who completed the questions on Continuing Healthcare half (31) tended to agree or strongly agreed the plans would meet local need. A third (23) agreed they were comprehensive, slightly less agreed these plans would meet their personal needs (18).

Detailed comments relating to continuing healthcare highlighted a number of themes:

- Some concerns around CHC funding and whether this meets demand
- There was feedback in relation to the eligibility criteria and that sometimes people who need CHC do not qualify under the current system. There was also a feeling that eligibility for CHC should be extended to support more people (for example more people with advanced dementia, carers, and more people with complex needs, long-term conditions and disabilities).

- There was support for closer collaboration between health and social care in relation to CHC
- More needs to be done to raise awareness of CHC among health and care professionals to ensure people are getting the support they need
- There were also comments about the importance of monitoring quality of care and holding providers to account, where needed.
- There were also specific queries around process and what happens if clients overspend on their Personal Health Budgets and then need additional support.

"There needs to be a serious commitment to improving knowledge, awareness and understanding of CHC, health and social care needs and Personal Health Budgets. Guidance and protocols are needed that staff can follow to ensure good practice and avoid frequent reassessments. We also need more signposting."

"[The assessment process] should be simplified. The process is adversarial, stressful… and decisions take too long"

Commissioner Response

The CCGs follow a national framework, which sets out how applications for CHC should be managed, including the process for assessments. We recognise that the current process can feel complicated for clients and relatives and NHS England is currently reviewing elements of the process, including the Decision-Support Tool (DST), which is used for assessments. We are expecting to receive information on any changes to the national process shortly. If changes are planned, we will ensure these are embedded into our local processes.

In terms of eligibility, entitlement to CHC is assessed in compliance with a defined legal document known as the CHC National Framework. CHC is available to a wide

range of people based on individual need including those with dementia, adults, the under 18s and people with complex needs, long term conditions and disabilities. Under this framework, common eligibility criteria are applied across all CCGs. Carers who look after individuals in receipt of CHC can be referred to the local authority for assessment under the Care Act 2014 where this remit lies.

We monitor service quality across all our providers, including care homes. All providers of care (care homes and domiciliary providers) must sign an NHS contract, which outlines the standards of care expected.

The Surrey CHC Contract Manager meets regularly with all providers as part of robust contract managing. Quality is also monitored through the Care Quality Commission, which produces independent reports on health and care providers and these reports are shared with us to help inform our commissioning plans.

We recognise there is an on-going challenge around raising awareness of CHC generally, including among medical and care professionals. To meet this challenge

we are rolling out training across the county including ‘fast track’ training to improve wider understanding of CHC.

We are also seeking funding to develop a digital App to provide information, guidance and advice on CHC. CHC also has a patient and carer forum and we are always keen to welcome new members.

With regards to Personal Health Budgets, we have a robust monitoring process is in place to help clients manage their PHBs. This helps us identify if client’s individual needs are being met, or if additional support is required, so we can work with them to amend their personal plans as needed. This means we can be flexible to ensure they are receiving the support they need.

3.4 Mental health and well-being

Of the 94 people that completed this part of the survey, the majority agreed that the plans would meet the needs of the population. However 31 people disagreed with this statement and others did not comment. When considering if these plans would meet the needs of them as individuals and their families, the majority disagreed that these plans would meet their own needs and the majority of respondents felt insufficient detail was provided in some areas, disagreeing that the plans relating to mental health were comprehensive.

As part of the feedback we received a high level of detailed feedback relating to mental health services (significantly more feedback than we received for other areas) and this included many people sharing their personal experiences and some concerns. These comments are summarised below and give greater insight into why many respondents felt further work and further detail was needed in relation to our plans for mental health commissioning.

The main areas of feedback came under the following themes:

Access to services

- There was a feeling that a gap in service exists for those who need a medium level of support to help manage their mental health issues
- Whilst there was some support for having a ‘single point of access’ for local services, it was felt this would only be effective if both statutory and voluntary organisations are involved
- There were some concerns about waiting times for some services, including access to psychological support and counselling
- There were also a small number of people who had concerns about processes that are undertaken, particularly in relation to assessments and whether these are being carried out appropriately and in line with policy
- There were some concerns raised about fragmentation of services and experiences of people being passed between services without accessing the support they needed, and a need to address this through better co-ordination of care

- It was felt more needs to be done to identify those with mental health issues, given many people may have not been diagnosed
- It was felt that services need to be better promoted so people understand what's available and how to access help. A need to better promote the crisis line and other crisis services were also mentioned.
- It was also felt that a greater focus is needed on suicide prevention
- There were some concerns about the level of support for young people experiencing mental health problems and feedback that a wider range of services are needed to support these individuals

Safe havens

- There was feedback around access to services and how services needed to be local. This issue was also mentioned in relation to safe havens and the need to keep these local as many people cannot easily travel to other locations
- There was support for safe havens and support for the opening times being extended and for more safe havens across the county to increase access. However there were some concerns about how safe havens were being used and how these needed to be for all mental health service users (including those with anxiety and depression) and not just for people with alcohol and substance misuse issues.

Improving access to psychological therapy

- There was support for increasing access to face-to-face sessions as it was felt there is currently only limited capacity for people to receive this, although it was recognised that online and telephone support are also available.
- There was also feedback in relation to current waiting times for Improving Access to Psychological Therapy (IAPT) services and the need to reduce these
- There was also a feeling that the IAPT programme focuses more on crisis care and that it needs to focus more on depression, anxiety and other moderate mental health issues which are equally important
- It was felt IAPT services could be more efficient if they stored an individual's data. An experience was shared of someone having to repeat all their background and history when they were re-referred onto the system and how this step seems unnecessary if they have already accessed the same service and provided this information
- There was also some concern that there is currently a gap of service provision for some people and that after they have completed an IAPT course limited support is available elsewhere

Inpatient units

- There was feedback around inpatient beds and whether the current capacity is sufficient to meet local needs. Examples were shared of where patients had been admitted to general wards due to no available bed capacity and the issues around this.

- Following discharge from hospital, the importance of robust care plans that outlined ongoing care and support was highlighted. It was felt that currently insufficient support is provided following discharge in some cases.

Care planning and co-ordination

- There was a feeling that greater focus is needed on care planning and co-ordination and that this needs to involve individuals and their families or carers where appropriate
- There was also support for closer collaboration and better integration of services to ensure care is patient-centred
- It was felt that a gap exists on clinical systems with some GP systems not including information relating to care plans and mental health support and that information needs to be better co-ordinated between services
- It was recognised that mental health links to all other areas of health services and that every area of planning (including urgent care, integration, primary care) needs to consider mental health clients, and not just look at this area in isolation
- It was felt greater focus should be given to primary care prescribing in relation to mental health and that closer co-ordination with pharmacies is needed
- We also received feedback around the involvement of family members, who can help inform care planning and may offer a different perspective to ensure an individual's day-to-day needs are being met.
- It was felt that stronger links should be made with other agencies, including housing and that the Homelessness Reduction Act, which comes into force in April, presents an opportunity for closer working and ensuring the wider well-being of these individuals is being addressed

Community-based care

- It was highlighted that GP practices and GPs can play a crucial role in mental healthcare, having developed relationships with individuals and there were some concerns raised that additional GP capacity is needed to help meet local demands
- There was support for extended GP appointments for people with more complex needs, including those with mental health issues, as well as feedback around a need to consider a patient's wider well-being and not just treat their physical symptoms
- There was a view that additional capacity needs to be provided for supported living
- It was felt a greater focus is needed on prevention and early intervention
- The 'recovery college' concept was cited as a good example and one that should be rolled out more widely
- There was a view that our plans should include more on the role of local communities and how they can support people with mental health issues. The dementia friendly communities was given as an example of where this has worked well.

- There was strong support for mental health citizens advice outreach services and the support they provide and support for these being more widely available
- There were examples given of where community funding and grants have been reduced and the need to ensure funding is retained to ensure support continues to be available

Dementia

- It was felt that more support for people living with dementia is needed, including out of hours
- It was felt a greater focus is needed on diagnosing dementia earlier
- There was support for more dementia networks and support groups, given the benefits to people with dementia and their families and carers. This needs to include a range of activities including walking groups, social clubs, music and other activities.
- The issue of the role communities can play, for example through dementia friendly initiatives was also highlighted

Perinatal mental health

- There was support for our plans in relation to perinatal mental health and the work underway around this
- A need for more education and awareness of this area was highlighted so new mothers know the signs to look out for (including the benefits of a good diet and other factors that can help general well-being)
- There was also a feeling that perinatal mental health also includes fathers and this area needs greater focus and recognition

Workforce

- There were some concerns about the availability of skilled and trained professionals to achieve our plans
- There was a feeling that more staff are needed in community and acute settings to support mental health, particularly in relation to suicide prevention
- There was support for more training and awareness around mental health among health and care professionals and particularly more training for GPs to support early diagnosis
- It was felt more psychologists are needed to reduce current waiting times
- Concerns over continuity of care and a high turnover of staff were highlighted and the need for longer-term workforce planning
- It was felt more mental health nurses (CPNs) are needed to support community services

Reducing inequalities

- Suicide prevention work should focus on the groups that are at greater risk such as men and those from LGBT communities
- Specific reference to military personnel and veterans should be included within the plans

- Supporting people who are homeless and making sure they receive mental health support was highlighted
- It was felt that some services need to do more to comply with the requirements of the Accessible Information Standard to ensure that information is fully accessible to patients, including those with specific communication needs
- The plans need to link mental health issues caused by other long-term health issues such as cancer, diabetes and other chronic illnesses, particularly where there is no "recovery" and mental health issues will be long term

"Much more needs to be done to support those with mental health needs in the community"

"There seems to be a middle ground of sufferers who are not severe enough to need 24/7 care and support, but their mental health effects their lives on a daily basis, making the simplest of tasks seem insurmountable."

"A lot more has to be done to provide mental health support to patients after they have been discharged as at the moment they seem to be left to their own resources and do not receive enough follow up care"

"If you have to wait to see somebody for dementia, it could get worse. If you don't have dementia, seeing somebody will put you off worrying about it"

"Mental health is often made worse by problems with benefits (being unaware of entitlement, claiming process and rights to appeal), family relationship difficulties and debts. Special Mental Health Citizens Advice is the only place I know that is able to provide help with sorting these and many other issues"

"Mental health and wellbeing is as important as physical and they are often closely bound together"

Commissioner Response

Access to services

We understand people need to be able to access the help and support they need quickly to prevent them from going into crisis and we monitor waiting times closely. If capacity issues arise we work with providers to address these to ensure patients are seen as quickly as possible.

A development that will come into place in 2018 is the Single Point of Access for people in a mental health crisis which will have a directory of service including voluntary sector and help to ensure that people are able to access the right service in a timely way for their need. This is expected to create a streamlined pathway for people but further development is planned for wider integration through the Surrey Heartlands Health and Care Partnership so that experience of services being fragmented will be improved.

We recognise the importance of retaining local services and we are working with a variety of providers to offer services that provide choice and flexibility closer to the people using the services

We aim to develop services that keep people well physically and psychologically.

Improving access to psychological therapies

We commission these services from a range of different organisations. This ensures people have a choice of which service they are referred to, as well as a choice of the type of support they receive (eg. face-to-face, online or over the telephone).

We monitor referrals (including self-referrals) and wait times into these services and continually review this to ensure enough capacity is available for people who need this support.

Safe havens

The safe havens are proving to be an effective model of care with open access for any adult feeling that they are in distress that require a mental health intervention outside of normal working hours (i.e. 9am-5pm). The service is complimentary to other services such as Community Connections and as such, service users have various options to access other services as required. Based on need, and in conjunction with other health and social care services, the Safe Haven operating model is regularly reviewed to ensure the best service is available to our population. We are aware that people would like more Safe Havens at a local level however the resources for this level of service is not available currently but the Safe Haven Model is being extended to young people under 18 years based on the success of the adult model of care.

Inpatient beds

As part of our plans, we commission a variety of services which meet the population needs. This includes both acute and specialist in-patient services and community services. We want to support people in crisis and we also want to prevent crisis from occurring. We have commissioned services across health and social care that work with service users to recover and live well.

We continually review services to ensure there is capacity to meet local needs and we will continue to monitor this closely. Our main provider is commencing a refurbishment project that will increase inpatient bed capacity in Surrey and reduce out of area placements. We aim to have a future model of care that meets the needs of our population and we are using the Mental Health Five Year Forward View to guide our planning processes.

Care planning and co-ordination

We recognise the benefits of closer working with other agencies, particularly in relation to delivering more person-centred care, and the closer integration of services, including across health and social care, is a key focus of our wider plans – and our plans to improve mental health care.

This work is happening at a local level and also through the work happening as part of the Surrey Heartlands Health and Care Partnership.

Community-based care

We work closely with primary care colleagues to offer more GP services and, as part of a national drive, opening hours for many GPs surgeries have now been extended, meaning additional appointments are now available during evenings and at weekends. The range of services available through health and social care is changing to meet the needs of service users and this will continue to be reviewed.

Further training for GPs on mental health has been made available across our area and will continue to available into 2018 along with work with Health Education England across our region on supporting training for GPs.

Dementia

We are working with GPs and other colleagues to improve early diagnosis of dementia and we will continue to take this work forward so these individuals, and their families, have access to the support that is available.

We recognise the impact the wider community, and local people, can have, particularly in relation to supporting people with dementia and we will continue to work with partners to support the range of dementia friendly initiatives that are already running locally. Our dementia strategy has been updated and reflects our future approach.

Perinatal mental health

We know this is an important area, and an area which needs greater focus, and this is being looked at through the Surrey Heartlands Health and Care Partnership with a bid submitted to the national team for funding a service in 2018/19.

We recognise all the of the areas of feedback that have been given in relation to this area and we will be sharing this feedback with the people involved in taking this work forward to ensure these areas are considered and addressed as part of our planning.

Workforce

We know that workforce remains a challenge in many areas, including mental health services, which require specialist training and skills. We factor this into our planning and workforce is another area we are looking at through a wider piece of work happening across the three CCGs and across the Surrey Heartlands Health and Care Partnership linked to the Mental Health Delivery Plan of the Five Year Forward View. Roles such as Peer Support and Associate Practitioners are being explored to help with the workforce shortage.

Reducing inequalities

The link between long-term conditions and mental health are well established and we recognise this as commissioners of local services. We are currently leading work to integrate IAPT services with existing long-term conditions pathways so these patients have access to any support they need and we will be exploring this area further as part of our wider plans.

We are also working closely with partners as part of a wider Suicide Prevention Board, which has developed a multi-agency strategy to address this area, working with local organisations.

3.5 Learning disabilities

Whilst there was strong agreement that the plans would meet the needs of the local population, more people who responded to this part of the survey (a total of 66) disagreed that they would meet their own needs and those of their families. There was no difference in the number of respondents who agreed or disagreed that the plans were comprehensive.

Free text comments relating to learning disability services highlighted a number of themes, with most comments focusing on elements of care planning:

Integrated care and multi-disciplinary working

- There was strong support for having one care plan that is centrally co-ordinated and updated by all members of a multi-disciplinary team and regularly reviewed (at least every six months) to ensure the client's needs are being met
- There was support for regular GP checks for people with learning disabilities to ensure these individuals, and their families are getting the support they need

Support for people with multiple complex needs

- Taking a person-centred approach – it was felt that more understanding is needed around learning disabilities often being part of a more complex disability and that a holistic approach is needed. An approach used in Derbyshire was highlighted as an example of good practice[1] , which resulted in a significant reduction in hospital admissions for people with learning disabilities (10.5 per 1000 as opposed to 70 per 1000 in other areas of the country).
- It was felt that wherever possible a family member, carer or member of staff who knows an individual well should attend appointments to support them and that this doesn't always happen
- There was a feeling that there needs to be greater recognition where an individual has multiple conditions and that this should trigger a high level of resource and higher levels of treatment and support
- Intensive support and supported living – it was felt that more supported living places were required. Transition to supported living and what exactly it entails was mentioned several times, with respondents wanting more information regarding options from people who have been through this major change.

Carers and engagement

- The contribution made by carers, and the need to make longer-term plans when carers (including family relatives) may no longer be able to provide care was highlighted. There were concerns around who would take on this responsibility and how this transition would be managed.

- It was also recognised that parents and carers are experts in this area and that their experience and knowledge can, and should be used, to help inform planning
- It was felt that health and social care should work more closely with education to ensure children and young people are getting the right support

Access and support

- Accessing services locally was highlighted as a challenge, where some services are not available, or commissioned, locally and the impact this has on carers and family members who need to travel further.
- There were also a small number of concerns around how people with learning disabilities access services including some delays in getting support (including social care), problems getting GP appointments and difficulties in being able to arrange annual health checks. The importance of care plans being developed in a timely way was also highlighted.
- Support for people with autism, especially those with behavioural issues, was highlighted as an important area in terms of service planning
- We also received feedback in relation to scheduling educational reviews for children who are born prematurely as problems in education often emerge later and that awareness of this needs to be increased in the education sector.
- It was felt that a greater focus is needed around transition to adult services and broader integration, including supported living and social inclusion

Workforce and training

- Staff training was also highlighted as an important area that affects care
- There was a feeling that greater awareness is needed among health and social care staff in relation to caring for people with learning disabilities, including autism, and that more education and training in this area would be helpful. Training to help staff develop effective communication strategies was a particular area that was highlighted.

Resources

- As with some other areas of feedback, there were some concerns around funding for learning disability services and whether this is sufficient to meet local needs

"People with learning disability should have one care plan to which all support teams contribute, and the case manager should check that the plans are actually being implemented."

"The multi-disciplinary approach to planning is essential but far more of a challenge to action than the short statement suggests. Our family [has been put] into crisis due to inadequate multidisciplinary involvement"

"Vital that support for families with a child or young person with autism or challenging behaviours is close to home. Too often families find themselves out of county to access support"

"Training is much needed within all hospitals in Surrey in autism training, aside from learning disability training, so all staff have an understanding; introduce "Autism Champions" within hospitals"

Commissioner Response

Integrated care and multi-disciplinary working

We are actively working with learning disability services to develop integrated models of care and closer working. There is work underway to support the sharing of information across systems to enable people to have a person-centred care plan that encompasses all needs across health and social care.

We recognise further work is needed in relation to the transition to adult services and this is a core focus for us over the next year.

Support for people with complex and multiple needs

Our transformation care programme, and the work happening across the Surrey Heartlands Health and Care Partnership is exploring all these areas and opportunities to improve care and support. This includes specific work to ensure the needs of people with more complex learning disabilities are being met throughout the range of services commissioned.

Carers and engagement

We recognise that meaningful engagement with people who use services, their families and their carers is essential and we are committed to seeking people's views on the planning and commissioning of services to ensure people's views and experiences help inform our planning.

As part of our work we review all commissioned services to ensure timely access to carers' assessments and we work closely with carer groups to ensure they are actively involved.

Intensive support and supported living

We recognise this is an important area and there is an intensive support service in place for adults with learning disabilities and/ or autism and challenging behaviour. We have also commissioned a children's intensive support service, which is currently forming and will be operational within the coming months.

We recognise that transitions in care can be stressful and that having the right information at the right time is invaluable in supporting major decisions and we will continue to work with our adult social care colleagues to ensure that information is available including details of care models and pathways.

For those individuals who shared their own personal experiences and said they would welcome support with their decision-making, we would encourage them to contact their local CCG so we can provide any additional help and support needed.

Access and support

Through our Surrey Heartlands work our transforming care Programme Board is actively working to ensure that people with learning disabilities have care as close to home as possible.

We are working with primary and secondary care in relation to integration to ensure reasonable adjustments are in place to support people with learning disabilities to ensure they have access to mainstream healthcare services, as well as access to more specialist support where this is needed.

We monitor the delivery of annual health checks by local services and we are concerned to hear feedback from a small number of individuals who have said they are having difficulty in accessing these checks. We would encourage anyone who is experiencing difficulties to contact their local CCG mental health commissioning team for advice and support. We are also expanding these checks to include younger people (over 14 years) as part of the transition into adult services.

Workforce and training

We have learning disability liaison services available in all hospitals across the county and these services provide specialist support and training to staff across all disciplines. We recognise that further awareness and greater understanding of the needs of people with learning disabilities would be beneficial in improving care and people's experiences and following this feedback it is an area we will explore further.

We are already working with partners through the Autism Champion network and other networks to develop further autism awareness training and will continue to take this forward.

Resources

We are committed to delivering further improvements in learning disability services for local people and we will continue to invest in this area to ensure needs are being met.

We are actively working to develop new models of care that will deliver care closer to home and help ensure services are meeting local needs and sustainable longer-term.

3.6 Safeguarding

There was a lower number of responses to this section of the survey (61 responses), compared with other areas. Of those who responded, the majority of respondents were undecided on whether these plans were comprehensive or whether they would meet the needs of the local population and those of respondents and their families.

Detailed feedback relating to safeguarding highlighted a number of themes, with most comments relating to a need for more information and more detail on how we are meeting our duties.

- Ensuring key groups are involved in our work and that our work covers the full range of areas it needs to under safeguarding legislation

- Ensuring that robust procedures exist to identify adults and children at risk; that these are fully accessible for people with different communications needs and that robust monitoring takes place
- There were also concerns raised relating to workforce and whether staffing levels are adequate in this area, as well as some concerns relating to staff turnover and how staff are supported to ensure staff and their skills and knowledge is retained.

"Surrey has issues when it comes to Safeguarding, and this section needs to put a lot more detail in, if the aim is to deliver excellent safeguarding for those at risk"

Commissioner Response

We recognise this is a very serious, and very important area of our work, and we have comprehensive systems and plans in place. Further information relating to our detailed plans can be found in our final full Commissioning Intentions 2018/19 document, which is available on our website.

To provide a summary of our plans, the priorities of our Surrey Safeguarding Children's Board (SSCB), Surrey Safeguarding Adults Board (SSAB) and NHS England include:

- Domestic abuse
- Child Sexual Exploitation
- Looked after Children
- Early Help
- Modern day slavery
- Prevent
- Independent Inquiry into Child Sexual Abuse
- Female Genital Mutilation
- Mental Capacity Act and Deprivation of Liberties

Each of these priorities runs through the contracts of services commissioned by Surrey Heartlands CCGs and by working with partners the CCGs will continue to safeguard all in the local population regardless of age, ability, race, gender, mental health etc.

Across Surrey Heartlands' our principal philosophy is that safeguarding is everybody's business and all staff will respond and act to raise safeguarding awareness and address any emerging issues.

The Joint Accountable Officer has overall responsibility to ensure that the CCG complies with all legal, statutory and good practice guidance requirements in relation to Safeguarding Adults and Children. The CCG's safeguarding policy and procedures details the layers of accountability and responsibilities of various professionals in providing a robust and effective safeguarding service.

Surrey Heartlands CCGs will work closely with partner agencies to ensure there are effective safeguarding referral pathways, inspections are rigorous and the most vulnerable in our society are safeguarded. This will be achieved through collaborative working and membership of the Surrey Safeguarding Children's Board and the Surrey Safeguarding Adults Board.

The CCGs, with partners, will also monitor the work of the Multi agency Safeguarding Hub (MASH). If any gaps in safeguarding service provision are identified they will be addressed and rectified.

We would like to give assurance that Surrey Heartlands CCGs will ensure all aspects of safeguarding and protection are discharged effectively, making sure all services commissioned have sufficient members of staff employed to keep the local population safe from harm and that they are trained and qualified to meet the requirements of their role. This is rigorously monitored through contract monitoring data collection, supervision and audit.

3.7 Carers

Just under half of those that responded to this section of the survey (74 in total) tended to agree or strongly agreed that the plans would meet the needs of the local population; however, when it came to meeting the needs of respondents and their families, there was no difference in those that agreed or disagreed with this statement. Furthermore, most people that responded to this section tended to disagree or strongly disagreed that the plans were comprehensive.

Free text comments relating to carers can be summarised into three main areas: feedback relating to young carers, parent carers and access to funding and support.

Young carers

- Concerns about recognition of and support for young carers were the most common theme in the feedback
- A need for greater awareness among health and care professionals, and the wider community, of the role of young carers and the challenges they face, including more training, particularly in education
- A need for more young carer support groups locally to give young carers access to support and information. It was felt that currently young carers have to travel some distance to attend groups, which may not always be possible due to their caring responsibilities.

"More care must be given to young carers"

Parent carers

- A need for more support and greater understanding of the role of parent carers, who will be carers for life. It was felt that more specialist support for parent carers is needed, given the impact it can have on their own health and well-being.

- Concerns were also raised around the transition from child to young person to adult and the need to improve the transition process, to give parent carers more support, involving other agencies where needed

"We tend to be the forgotten as we are parents and parents should give support!! We greatly need more real support and recognition"

Access to and funding for carer support

- Comments were also made around funding and support, with concerns that funding levels, and the support available, is not meeting local needs
- There was also feedback about the importance of being able to access support out of hours at evenings and weekends
- Support for the Carers Prescription Service, which is currently being rolled out and a need to continue to raise awareness of this service

"The best help for carers is knowing there is easily available help, someone to turn to when problems arise. Most problems appear in the evening and weekends"

Commissioner Response

Young carers

We recognise the needs of young carers and, having maintained funding, we plan to promote more young carers awareness across the system. We will do this by providing more training and developing resources to support professionals such as the Young Carers Pathway, Young Carers Script and NHS Young Carers Pledge. Commissioners are working in partnership to achieve awareness of young carers across the system.

Commissioners also recognise that many young carers choose to care and this can be a life enhancing experience. The Children and Families Act 2014 provides new rights for young carers and a whole family approach to support. Our focus has been to alleviate inappropriate levels of caring. Our young carers' service works in collaboration with educational institutions to support better educational outcomes for young carers. We have a specialised young adult carer's service 18-24years.

With regards to young carer support groups, groups are provided and our new providers ensure that young carers are invited to an initial event within eight weeks. This includes support with transport arrangements. We recognise that there are many other clubs and activities and social events that young carers can access including the new Children and Young People's Safe Havens.

Parent carers

Parent carers are included in our new Adult carers support service, which is developing a new parent carer strategy. We continue to progress the work around the recommendations of the Family Voice Surrey Health Impact on Parent Carers Report 2017.

We have as part of our adult carers support contract a specialist parent carer lead and we work closely with other partners such as Surrey Family Voice to raise the profile of parent carers.

Commissioners recognise that there is more to be done around transition. We have a dedicated Carer Practice Adviser working in Adult social care that supports transitioning families. We also have a young adult carers' service.

Accessing services and funding

Plans put forward in the joint commissioning intentions aim to meet carers' needs within the resources available and opportunities to improve service provision are continually sought.

In response to feedback about the importance of carers being able to access help out of usual working hours when needed, the provider of carer support in Surrey is planning to pilot out-of-hours support, which could complement other support such as the Surrey Carer's Prescription and GP Carer Breaks. We continue to roll out the Carers Prescription Service and we will continue to raise awareness of this service in 2018/19.

3.8 Cancer

Of the 59 people that answered the survey questions regarding cancer, almost two thirds tended to agree or strongly agreed that the plans were comprehensive and would meet the needs of the local population and respondents and their families.

Comments relating to cancer services highlighted the following themes:

- Some concerns over access to cancer screening services and the quality of care being provided in some cases
- The need for patient communications to be accessible and written in plain English, particularly in relating to inviting people in for screening
- The important role carers play in supporting cancer patients was highlighted. This feedback was consistent with the feedback included in the carers section, with a feeling that more help and support would be welcomed
- Some concerns around funding for cancer care and the need for more funding, with the UK being behind other countries in relation to cancer outcomes and survival rates

"Cancer screening letters sent on behalf of GPs need to be accessible to recipients who are lip-readers, visually impaired or for whom English is not their first language (including BSL)"

"As a carer of people who had cancer and strokes - I know how much support I needed and how much advice, guidance and skills are needed"

Commissioner Response

As CCGs we continue to focus on delivering improvements in cancer care locally and this includes work underway to support early diagnosis, as spotting cancer early means treatment is more likely to be successful. We recognise that outcomes in the UK are behind some other countries and we have plans to improve care and support across a range of areas.

Surrey and Sussex Cancer Alliance has put forward early diagnosis and living with and beyond cancer bids for transformation funding. Should these be successful, we are hopeful that some funding will come down to support cancer transformation work at each CCG and/or at Surrey Heartlands Partnership level.

We recognise the importance of accessibility, accessible patient information and compliance with the Accessible Information Standard. As CCGs we work with our providers to ensure these requirements are being met. CCGs do not commission the screening services referred to (these are commissioned by NHS England) so we will make sure we pass this important feedback on.

With regards to carers, we have a range of plans to help support carers and these are described in the previous section relating to carers.

3.9 Diabetes

There was general agreement amongst the 30 out of 57 respondents that completed this part of the survey that the plans would meet the needs of the local population. There was less agreement that the plans were comprehensive and would meet the needs of respondents and their families. However, comments regarding diabetes did identify a number of concerns that need to be taken into account in future service planning.

Comments relating to diabetes and diabetes services highlighted the following themes:

- The importance of work with communities to prevent diabetes through lifestyle choices where possible
- The importance of having access to specialist services to prevent complications
- The need for regular reviews for diabetes patents to ensure needs are being met
- Support for more structured education and a need for this to be well promoted and accessible

"There need to be better individually tailored support services to help people lose weight, eat healthily etc. This needs to be a collaborative process where individuals are helped to identify goals, how they might start to achieve one of these and given the right support, incentive to achieve and carry on"

Commissioner Response

The three CCGs are in the process of implementing the National Diabetes Prevention Programme, a nationally funded structured course including education on healthy eating and lifestyle, help to lose weight and physical exercise programmes tailored to individual needs for people at risk of developing diabetes.

The CCGs have been awarded transformational funds to improve diabetes care. The three key domains of the programme are:

- Increase in uptake of structured education
- Development of inpatient Specialist Nurses roles
- Increase the number of patients who are achieving the three treatment targets in blood glucose (HbA1c), blood pressure and cholesterol. More information about our Diabetes Transformation programme can be found online at:http://surreyheartlands.uk/our-priorities/clinical-pathways-old/cardiovascular/diabetes-transformation-programme/

3.10 Stroke

Of those that responded to this section of the survey most (58) tended to agree or strongly agreed that the plans were comprehensive and would meet the needs of the local population and those of respondents and their families.

Comments relating to this area covered the whole stroke pathway from the initial ambulance response right through to treatment and rehabilitation. The main themes were around:

- Ambulance response times and the need to monitor these, especially for people who live in more remote areas and may have longer journey times to a stroke unit
- Following discussions relating to local services, and if these should be reorganised, there was support for Epsom Hospital to remain as a Hyper Acute Stroke Unit due to its location and the population it serves and the ease of access for local people.
- There was support for therapy in community locations, close to home
- It was felt that increased community support is needed for those with an acquired brain injury resulting from stroke
- There were some concerns about what happens when patients are discharged from rehabilitation care and if this means they are no longer getting support to continue their recovery
- Accessibility and the promotion of eSMS text calls from mobiles to 999 for lipreaders and BSL users was felt to be important
- There was also feedback that a 112 emergency line for people on holiday abroad who have suffered a stroke should be better promoted to help increase fast access to support and support ongoing rehabilitation once home

Commissioner Response

Improving stroke care from onset through to support in the home is a key focus for the three CCGs, following the outcome of the Surrey Stroke Review.

As a result, the three CCGs have increased investment in stroke services to support improvements in line with the South East plan and learning from London stroke review.

From April 2018 patients in Guildford and Waverley and North West Surrey will be supported through a new pathway providing specialist care at a hyper-acute stroke unit followed by care in an acute stroke unit. Rehabilitation and early supported discharge are key features as well as the introduction of a stroke navigator, increased psychological support and a 6 month review. The stroke navigator role is specifically aimed at helping patients and carers through the pathway and signposting to sources of further support and advice.

Epsom remains the stroke unit for Surrey Downs patients and has received additional investment to support pathway development in line with the outcome of the Surrey Stroke Review.

The Surrey Stroke Oversight Group monitors patient flows and the CCGs are working with South East Coast Ambulance Service regarding ambulance response times for all emergency calls including stroke.

The use of eSMS to 999 for lip readers and BSL users, as well as 112 for suspected stroke when on holiday in Europe, will be shared with the Surrey Stroke Oversight Group for inclusion in our plans.

Key information on the stroke pathway can be found here

3.11 Adult social care

Of the 81 people who completed the questions on adult social care over a third (36) agreed the plans would meet local need. Under a third agreed the plans were comprehensive and would meet their personal needs – it should be noted here that a number of people (20-22) neither agreed nor disagreed with these questions.

The following key themes were identified from the feedback for adult social care commissioning intentions:

- Role of partners/voluntary sector - it was felt there should be a greater focus on developing and supporting the voluntary sector, including neighbourhood watch schemes, recognising the contribution they make to the community and to individuals who may otherwise be isolated.
- There was a feeling that greater reference is needed in plans relating to home-based services for people experiencing mental health problems
- There were concerns over funding for adult social care and whether funding was sufficient. There was support for joining budgets to help the system work together more effectively.

- The importance of integrated care was recognised. However, there were some concerns around governance and accountability and how this would work
- Access to, and quality of, residential care was mentioned in the feedback and a need to ensure high quality services are being provided
- People and organisations need to understand what care and support (including benefits) is available and how to access it
- There was feedback around people with disabilities and complex needs who are not always suited to independent living. It was recognised that those who need more support would benefit from living in a community setting.
- It was felt a shift in culture is needed to ensure delivery of the Care Act
- It was felt more support and more funding is needed for people with acquired and traumatic brain injury and brain injury carers' support.
- There was support for greater co-ordination between different organisations and more multi-agency working. It was felt more needed to be done to co-ordinate plans with public health in relation to stroke prevention, hypertension and reducing risk.
- There was also support for a more formal structure for engagement locally and regionally

"Problems often develop when a client needs to access a range of different services- they may require support from several different service areas."

Commissioner Response

We value the comments and feedback that people have taken the time to submit in response to the Commissioning Intentions consultation. The feedback will be used by Surrey County Council to inform the more detailed consultations that the council will carry out should the intentions mean that there will be any significant changes to services.

3.12 Medicines management

Of the 68 people who completed the questions on medicines management almost two thirds tended to agree or strongly agreed the plans would meet local need – just under half agreed the plans were comprehensive and meet personal needs.

Comments relating to medicines management highlighted the following themes:

- Skilled professionals: pharmacists are well-trained and qualified and can help with treatment and advice. They can support with screening, monitoring and sign-posting patients and can work closely with GPs.
- Some felt better communication is needed between GPs and pharmacists and different hospital departments.
- There was support for a 'personal medicines record' which is shared with people involved in an individual's care
- There was support for reducing cost and waste through patient education, standard packaging, pre-dispensing trays, making simple drugs non-

prescription, allowing trained pharmacists to prescribe and encouraging self-care for minor conditions.

- In relation to hospital discharge, it was felt there is a need for pre-discharge reviews and quicker dispensing. There was support for making more hospital drugs available in the community.
- Further details on how our plans would be implemented and what impact we would be aiming to achieve would be welcomed
- There was support for closer working with pharmacists, automated repeat prescriptions and frequent medicine reviews
- The importance of having pharmacies in rural locations was recognised
- There was support for greater education, for example around issues such as antibiotic prescribing
- There were some concerns around the anti-coagulant service and its effectiveness
- There was feedback around stoma and continence products and how these are commissioned, and a need to ensure products are available as needed
- There were some concerns about reduced patient choice and less market competition due to some products being streamlined
- Evaluation to help inform planning and best practice was also recognised as being important

Commissioner Response

Skilled professionals

All pharmacists undergo extensive undergraduate training and are required to update their knowledge through Continuing Professional Development every year to maintain their professional registration. Links with GPs are established by Community Pharmacists to enable national services e.g. new medicine reviews and medicine use reviews. Pharmacists employed by Clinical Commissioning Groups (CCGs) liaise with GPs and hospitals to facilitate access to appropriate medicines for individuals and the local population. The CCGs support the strengthening of these links and although not responsible for the community pharmacy contract, will work with local pharmacists and their representative bodies to provide locally appropriate services e.g. implementation of a system to transfer discharge information to community pharmacies.

Better communication

Extended access to information contained in a patients summary care record could improve communication between GPs, pharmacists and hospital departments. Locally, there are policies in place to guide information transfer but we have noted that community pharmacies are not currently included in this and so are supporting the introduction of a system to improve this. The CCGs agree that a wider range of methods to access information should be available and locally will attempt to address this on an individual service basis and feedback to NHS England for national support.

Reduce cost and waste

These are aims of any service redesign in relations to medicines optimisation. Some of the suggestions made cannot be implemented locally (e.g. standard packaging and making simple drugs non-prescription, which would need to be taken forward nationally). However pharmacist prescribing will become more widespread and the CCGs will encourage this as an option when appropriate for new and updated services. The CCGs will also be implementing national guidance for encouraging self-care.

Hospital discharge

Local hospitals are working hard to improve the discharge process for patients and it should be noted that the wait for medicines experienced by some patients may not be due to slow dispensing but a delay in the prescription being written. There are some limitations to access to "hospital" drugs in the community but CCGs will support prescribing by GPs and/or alternative supply nearer to home if there is a safe and legal way to do so.

Use of pharmacists in GP practices allows an enhanced service in relation to medicines on an individual patient basis. Collaborative plans will consider using the current and future pharmacy workforce differently to support prevention, self-care, optimisation of prescribed medicines and reduced waste. Plans have also been put in place to encourage the better use of antibiotics through the provision of GP advice and delayed prescribing - in line with national guidance.

Finally, CCGs are working together to implement the 2015 NICE guidelines on Medicines Optimisation to co-ordinate knowledge and implement best practice. This aims to ensure that medicines provide the greatest possible benefit to people by encouraging medicines reconciliation, medication review, and involving patients in decisions about their medicines.

3.13 Guildford and Waverley CCG – local feedback

Urgent and emergency care

The main theme from this local feedback was in relation to the CCG doing more to promote the range of services available in the community to help people to self-care. There was also support for promoting pharmacists more as they can provide advice and support with treatment without the need to go to a GP or to A&E.

"Education of the public is needed to signpost where to seek appropriate help for their condition or ailment to help prevent A&E admission. It is great to have plans in place for alternative care and support but unless the public is educated they will still attend A&E"

Planned care

The main area of feedback in relation to planned care was in relation to diagnostics and support for all tests and scans being scheduled to take place on the same day, where possible, which would be more convenient for patients, including those living in care homes.

"Residents receive multiple appointments for scans and checks on different days at the hospital – should be able to have all their checks on one day so do not have to transport them all the time – disruptive" (care home member of staff)

Out of hospital care

Whilst there was some support for the plans for out of hospital care in Guildford and Waverley, in common with other areas, there were some concerns that the funding available to properly develop robust, high quality out of hospital care may not be adequate.

There was also feedback and support for the community hospitals.

"[We] feel strongly that there is an urgent need for {a community hospital in our area] because of the growing population here due to a great deal of new housing, the ageing population"

Primary care

There was considerable concern about the capacity of current primary care services, especially GPs, to provide extended opening hours during evenings and weekends and a request that such extended hours should be prioritised for urgent care only.

There was also concern that primary care administration staff are already stretched with no capacity to take on additional roles. There was also support for greater engagement and involvement in developing primary care services if this engagement is meaningful and if feedback helps shapes our plans.

"I would like to see resources committed to extended hours used for urgent out of hours care only"

General comments

There were other comments about the CCG's plans and priorities. These general comments covered a broad range of commissioning areas including:

- Concerns around the availability of a trained workforce
- Support for carers
- The implementation of the armed forces covenant and the Accessible Information Standard by providers
- The need for a holistic approach to individual care that does not treat physical and mental health needs in isolation
- Not having to repeat information to different teams and agencies
- Working with partners more effectively to prevent suicide and
- Ensuring that people living in rural and more isolated parts of Surrey were not disadvantaged by any of the plans

Commissioner Response

Urgent and emergency care

The CCG will work with Surrey Public Health and NHS England in 2018/19 to promote the alternatives to A&E. This will include extended access to primary care in October 2018 (see below).

Pharmacists do provide a valuable service and are part of the urgent care system. The CCG will continue to work with local pharmacists in 2018/19, providing additional training to enhance their clinical assessment skills to further enhance the level of service they can offer.

Planned care

The CCG is working closely with the local acute trust, the Royal Surrey County Hospital, in order to improve the efficiency of services. This includes a programme of work looking at new models of follow-up care, which includes developing one-stop clinics where possible. This programme also involves developing more virtual models of care in order to ensure that patients are only invited to attend a hospital appointment when absolutely necessary.

Out of hospital care

The CCG wants to ensure that the best care is provided at the right time in the right place; it is not intended to substitute hospital-based care for home-based care. We want to minimise the problems that can arise when frail patients spend too long in hospital (e.g. physical weakness and frailty) that can mean more support is required to return home.

Concerns regarding ability to pay for home-based care were also raised. All care provided by the NHS is free at the point of access and this includes community-based care. Social care however is means tested and some patients will be required to pay for their care.

The CCG will be carrying out a review of its community bed provision over the next 18 months to ensure the right services are in place to meet the needs of our population. This will include the estate facilities and provision of urgent care that meets new standards issued by NHS England. We will ensure that options are developed in partnership with the local communities and key stakeholders using co-design processes. This will be followed by public consultation.

Primary care

Whilst many practices already offer extended access on weekday evenings, there are some practices that don’t and weekend coverage is inconsistent. The CCG is required to provide 7-day GP access and is committed to delivering this in a targeted way. Weekend surgeries will be open according to patient need at specific times when patient need is at its highest. Pre bookable and urgent slots will be available. Appointments with nurses and Health Care Assistant (HCA) and other healthcare professionals may also be available. The CCG will be working to review this and tailor its approach accordingly.

The CCG is part of proposals to recruit GPs nationally and from overseas. There are also more opportunities for additional roles within general practice which include training nurses, and physician associates. Some practices are already employing pharmacists and paramedics. These initiatives have the potential to reduce GP workload by diversifying skill mix. In other areas GPs have been brought back into the system through flexible working arrangements, and this is something that the CCG will also be considering.

The CCG has various initiatives underway to support the development of administrative staff. These include active signposting and training in reviewing documentation related to patient care to identify actions required. Training administration staff to take a more active role provides them with career progression, job satisfaction and releases health care professionals to make the healthcare decisions.

The CCG intends to engage with patients specifically on the longer-term design of the 7 day working hubs, and this will be an opportunity for real engagement and the ability to shape the service design.

General comments

There are separate sections in the final joint commissioning intentions 2018/19 detailing the plans for carers, suicide prevention and implementation of the armed forces covenant.

Surrey Heartlands is focused on integrating health and social care in a holistic manner that places the individual at the centre of care and decision-making; the Surrey Care Record will ensure those that need to can access GP and other health and care records to provide the best care.

The CCG ensures it fully considers the needs of people living in different parts of Guildford and Waverley including its rural communities through robust equality analyses of all programmes; these are published on the CCG's website.

3.14 North West Surrey CCG – local feedback

Urgent and emergency care

The key themes from feedback on urgent and emergency care, which does also cover out of hospital care, were as follows:

- There was support for having a walk-in centre in Weybridge following the fire that destroyed Weybridge Hospital in August 2017, with people mentioning the benefits of having access to local care such as reducing the flow of patients to A&E and primary care.
- As well as having a service available in the local community there was support for publicising the different options so people make best use of available services.

"Closing the walk-in centre is Weybridge will be positively devastating for families who do not want to race up to a clogged A&E unit, and cannot get appointments with GPs, but need medical help."

Planned care

The key themes from feedback on planned care services (which includes operations and booked procedures) were around:

- The accessibility of sexual health services – lack of outreach services for young people and lack of information about where to go for advice and help.
- The use of online consultations and overall better use of information technology.
- The need to engage with the community with a focus on cancer rather than just on non-cancer and frailty.
- Services need to be available for patients with acquired and traumatic brain injuries.

Out of hospital care

The key themes from feedback about out of hospital care services, which includes community services, were around:

- Commissioners need to listen and engage properly with partners and acknowledge they intend to work jointly to address key issues affecting care. This was felt necessary to particularly address discharge arrangements. Integrating services into the wider system would result in a more supportive environment.
- The need for care homes to be considered an integral part of health care provision such that medical staff are integrated into services.
- Coordination and funding of End of Life Care and the importance of Hospices in delivering out-of-hospital care but not being suitably recognised in wider resource planning by Surrey Heartlands Partnership.

"Out of Hospital - partners truly need to be engaged and listened too - as there is much from a community setting that could be integrated into the wider system in support … they could mobilise a range of 'support' to assist persons returning home more promptly - and this should be more explicitly stated acknowledged as an area of activity to joint work on."

Primary care

The key themes from the feedback we received on GP services were around:

- The need for having GP appointments available in evenings and at weekends and concerns that this could negatively impact the resources (appointments) available during normal working hours.
- Supporting GPs to manage patients with multiple issues such as debt, housing, isolation through the introduction of a social prescribing model of care.

- The need for GP consultations to not just focus on physical health but to also consider an individual's wider wellbeing.
- Difficulties in making an appointment in the first place and not being able to get through on the phone; having to attend the GP practice to make an appointment.

"Most elderly and vulnerable people are free during normal working hours, and don't need appointments out of hours. By shifting the balance towards evening and weekend appointments you are shifting resources from the elderly & frail, and children & families, to the healthy adult population. Is this justified?"

Commissioner Response

Having secured temporary accommodation for the majority of services previously provided in Weybridge Hospital the CCG will be carrying out engagement with local communities and key stakeholders on its out-of-hospital strategy. The CCG is fully committed to maintaining healthcare services on the Weybridge site and options for future provision will be properly consulted on in line with the CCG's statutory duties.

The integration of health and social care is a key priority across Surrey Heartlands Partnership and we want to work with all partners, including care homes, to ensure that the right care is provided at the right time in the right place.

Extending access to primary care in 2018/19 is a priority for the CCG. The CCG will commission an additional 30 minutes of appointment capacity per 1,000 registered population every week. This equates to 185 hours of additional primary care clinical capacity each week across the North West Surrey area and will give an additional 38,480 appointments per annum.

This service will be commissioned to deliver these appointments across 365 days of the year and to distribute their delivery in each of our three GP Localities – Thames Medical, Woking and SASSE.

We will work with the provider of sexual health services in Surrey to ensure that service users are able to access this care when it is needed.

3.15 Surrey Downs CCG – local feedback

Urgent and emergency care

The key themes from feedback on out of hospital care services, which includes community services, were around:

- Hospital capacity and a perceived need for more funding, more staff and more beds to meet the demand for care. There were also concerns about the capacity of ambulance services to respond to urgent calls.
- There was positive feedback in relation to the care provided at Epsom Hospital. There was also feedback around the importance of maintaining services at Epsom Hospital if proposals to co-locate some more specialist services on one site at Epsom, St Helier or Sutton progress further. There were concerns about

potentially travelling further for some urgent care services if these were no longer delivered at both sites. There was also support for delivering the specialist acute services at Epsom and not at the other sites as it was felt that Epsom serves a different geography, with the other sites in close proximity to each other and other London hospitals.

- There was support for getting more people seen and treated and home on the same day and avoiding admissions where possible to help ease pressure on local services.

Planned care

The key themes from feedback on planned care services (which includes operations and booked procedures) were around:

- Alternative diagnostic services being made more widely available (for example the use of computerised tomography instead of x-ray and MRI scans and the opportunity to roll this out more widely)
- Making the new tele-dermoscopy service available at all Surrey Downs GP practices as this can help earlier diagnosis of skin problems, with patients seen much more quickly in the community
- More support being needed for patients who have a brain injury and their families, including more signposting to other services and more funding for other voluntary organisations
- Fast access to eye care services for older patients, particularly in relation to cataracts. Local eye services were felt to be important, particularly for people who do not have their own transport, and there was support for a mobile eye clinic to ensure services were as local as possible.

Out of hospital care

The key themes from feedback on out of hospital care services, which includes community services, were around:

- Recognising the importance of community services, especially for people who live on their own, and the valuable support they can provide
- A need to be able to better identify people who are isolated and need support to ensure they get the help they need
- Support for more home visits, where these are needed
- Support for social prescribing, which enables health and care professionals to refer people to other community services to support their wider health and wellbeing
- The use of technology and how this can be used to best effect to support local services and patient care
- More flexible patient transport services that take patients to all locations as necessary if they meet the criteria
- A need to consider staffing and workforce planning to ensure services are viable longer-term and a need to invest in additional community equipment, where this is needed

- There was also feedback around community services needing to make sure they actively seek, and listen to, feedback from patients

Primary care

The key themes from the feedback we received on GP services were around:

- Primary care workforce and a perceived need for more GPs
- A need for greater co-ordination between different agencies and different organisations
- Having longer GP appointments where these are needed to allow more time for a consultation, particularly where an individual's needs are complex and for people experiencing mental health issues.
- The need for GP consultations to not just focus on physical health but to also consider an individual's wider wellbeing.
- There was support for local GP services and for extended access (evening and weekend surgery appointments) where these have started.

General comments

We also received a number of general comments that were not in relation to the specific areas above. These were around:

- A number of people shared their positive feelings towards, and experiences of, the NHS and local services
- Supporting people with long-term conditions such as diabetes and how the CCG is addressing this area
- End of life care and what plans the CCG has in relation to this, particularly in relation to partnership working with the voluntary sector and local hospices
- There was feedback in relation to making sure the CCG is considering the needs of more rural villages in Surrey Downs and the challenges around this in relation to accessibility and transport and being able to access services
- There was also feedback around how the CCG will deliver its plans and priorities and the detailed implementation that sits behind the plans.
- It was felt greater focus was needed on how the CCG will work to reduce health inequalities
- It was recognised that ongoing, meaningful engagement with local people and service users would be needed in the implementation of these plans. It was also felt that the CCG should work more closely with local businesses, local communities, education and local authorities in the planning and delivery of local services.
- There were differing views on the use of independent healthcare organisations and independent hospitals in providing NHS services. Some people said they did not want to see this locally, whilst others recognised the benefits of shorter waiting times if additional capacity was found in other independent providers.
- There was also feedback around accessibility and the need to ensure all NHS organisations are meeting the requirements of the Accessible Information Standard, with accessible information channels used, translation services

offered to those who need them, wider use of SMS text services and communication methods that would support those who are visually impaired or have other disabilities.

Commissioner Response

Urgent and emergency care

In response to comments relating to Epsom Hospital, local commissioners - Surrey Downs, Sutton and Merton CCGs - are looking in detail at the challenges faced by Epsom and St Helier University Hospitals Trust and how we can best ensure high quality, safe and sustainable services are provided for local people in the years ahead.

The Trust has recently set out its own view of these challenges. They believe the best way forward is to concentrate their acute services on one of the Epsom, St Helier or Sutton Hospital sites. We don't yet have enough detail about the proposed model of care, the finances, likely patient flows and the impact on patients, to take a view on whether the Trust's proposed way forward is the right – or only – solution.

Whatever the future arrangement of services, the three CCGs and the Trust are clear that we will continue to need both Epsom and St Helier hospitals and that neither will close.

We will look at all the evidence and work with the Trust and local people to decide the best way forward. If any significant changes are proposed – such as a new hospital or any consolidation of acute services – commissioners would assess these and would fully consult the public before making any decisions.

Planned care

In response to the feedback around diagnostic services, we are currently reviewing these and this will include looking at X-ray, MRI and tomography and we will consider the feedback as part of this review.

We are also continuing to introduce the new tele-dermoscopy at other practices, where practices have expressed an interest in providing this service to patients and we will continue to roll this out.

Over the past year we have introduced a number of new community eye care services, focussing on increasing access where we can. There are a number of acute hospital providers and community providers offering cataract appointments within 30 days so we do not believe there is a need for a mobile eye clinic for cataracts at this time. If capacity and demand increases, we will re-look at this.

Out of hospital care

We are committed to working in partnership to improve health outcomes and we do this across the range of services we commission. For example, we have recently put a plan in place to promote better inter-agency co-ordination through a new partnership arrangement called the Integrated Dorking, Epsom and East Elmbridge Alliance (IDEAA). IDEAA will bring together professionals to provide adult community services that are personalised, joined up and patient-centred.

We are working hard to identify the right patients for care interventions through our Out of Hospital strategy. This includes alternative pathways such as social prescribing. The vision is to have a single point of access through which patients can access all their health and care needs.

Primary care

We are working closely with local GP practices and NHS England to increase access to GP appointments so people in Surrey Downs can see a GP in the evening and at weekends, addressing staffing and workforce issues through GP networks and closer working between GP practices.

We completely agree that health and social care services need to be more integrated and we have already introduced a number of new initiatives to help achieve these, such as our community hub service. Greater integration of local services remains a top priority for us and we will continue to look at ways to design new services with this at the centre.

We are also currently exploring new ways of working and this includes looking at how we can free up GP time so they can have longer consultations with patients who have complex health and well-being needs.

General comments

We have a comprehensive End of Life Strategy, which focuses on improving end of life care across six areas: early identification, staff training and education, care that is co-ordinated, services that are accessible and meet local needs, embracing new technology to improve communication, and bereavement support. The strategy was developed in conjunction with, and is being moved forward by, an End of Life Project Board which includes membership from commissioners, local providers (including hospices and the voluntary sector) and public representation from those with experience of caring for someone on an end of life care pathway. The group will also be working together during Dying Matters week (14-20 May), to increase public awareness of the project outcomes and to promote the national and local messaging of building Compassionate Communities.

We work hard to address local health inequalities and a lot of work is happening on this through the Surrey Heartlands Health and Care Partnership. We will take this feedback on board and we will make sure we explain more about this through our communications and engagement.

We are committed to meeting accessibility requirements and the Accessible Information Standard and we are working with partners to ensure our systems and processes are fully accessible for local people.

Detailed information relating to our plans and priorities in each area can be found in our final Commissioning Intentions 2018/19 document, which has been updated in response to the feedback we received.

4. Impact of engagement

As organisations we are committed to meaningful engagement and making sure that the feedback we received is used to help shape our plans and priorities, how we commission local services and how we work.

We have analysed all the feedback we have received and shared it with individual commissioning teams who are responsible for commissioning services in each area.

We have updated our Commissioning Intentions 2018/19 document and we have included a summary of the feedback we received in each chapter. We have also provided a response to the main areas of feedback.

In many cases our response gives assurance about work already happening in other areas that may not have been mentioned in the summary document. In other cases, it directly answers questions and queries and provides an update on developments where these have been requested. We have also said where we will be taking further action in response to feedback so people can be assured that we have heard the feedback and that we have listened to what people have told us.

5. Evaluation

As with any piece of engagement work we do, we will be thoroughly reviewing and evaluating our process, approach and the outcomes we have achieved through this process so we can learn and enhance our approach next time.

There were clear benefits to a joint approach that brought the four commissioning organisations together, including joint priorities for health and social care, however we would have liked to see higher engagement levels, particularly in terms of the number of survey responses. The qualitative data has provided us with some really valuable insights and has led to meaningful engagement with communities which can be harder to reach and seldom heard. However, given the total population size of the Surrey Heartlands CCGs next time we would want our engagement levels to be significantly higher so we can be assured that we are reaching a larger group of individuals and partners and that their views are helping to shape our plans.

We have also received feedback in relation to the survey design and format and whether this can be simplified if the process was repeated so this is also an area we will be considering further.

6. Next steps and how to get involved

This feedback report and our updated Commissioning Intentions for 2018/19 will be discussed at the three CCG governing Body meetings in March (these are meetings held in public so please see websites for details) and the Governing Bodies will be asked to approve the final Commissioning Intentions.

For more information about local plans and to get involved (for example in our patient groups and forums, local Practice Participation Groups and to receive regular updates on our work), please see our websites:

www.guildfordandwaverleyccg.nhs.uk
www.nwsurreyccg.nhs.uk
www.surreydownsccg.nhs.uk
www.surreycc.gov.uk

We would like to thank everyone who took the time to share their views with us as part of this engagement.

Your feedback has been invaluable and will enable us refine our plans and priorities to ensure we are meeting the needs of the communities we serve.