SURREY

NHS

Commissioning Intentions for Surrey Heartlands CCGs and Surrey County Council

2018/19

Have your say about our joint plans for health and social care in Guildford and Waverley, North West Surrey, Surrey Downs and Surrey County Council.

Complete our online survey from 17 January to 18 February 2018

www.surreysays.co.uk/deputy-ceo/commissioning

Contents

Surrey Heartlands

Health and Care Partnership

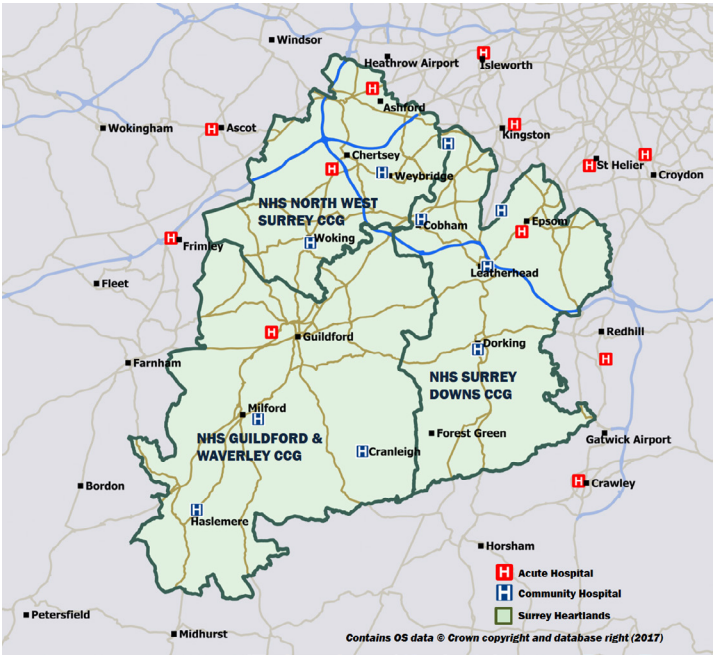
Local health and care organisations - Guildford and Waverley Clinical Commissioning Group (CCG), North West Surrey CCG, Surrey Downs CCG, Surrey County Council, acute hospitals, the ambulance trust, local GPs, community services and the mental health trust all share an ambition to integrate health and care services for the local population in Surrey.

Collectively, these organisations have come together as the Surrey Heartlands Health and Care Partnership to create a new sector-wide model of integrated care.

This partnership will work together to deliver the NHS Five Year Forward View (FYFV), focusing on:

- service and clinical pathway improvements
- the delivery of outstanding quality services for local people
- improvements in productivity and efficiency to ensure systems remain viable in the long term

Our five-year Sustainability and Transformation Plan describes how we intend to meet these challenges collectively.



Surrey Heartlands serves 850,000 people across nine boroughs with a combined health budget in 2016/17 of £1 billion and combined social care and public health budget of £328 million. Our partnership includes:

- 3 CCGs working through eight GP-led localities
- 684 GPs in 95 practices
- 4 acute hospital sites
- 11 community hospital sites
- 1 mental health provider operating from 4 in-patient sites and delivering community services from 22 sites
- 1 community health services provider
- 1 upper tier local authority (Surrey County Council) operating adult and children's social services and public health
- 9 district and borough councils

Commissioning Intentions

How we plan to buy health and social care services in Surrey

For 2018/19, the three Surrey Heartlands CCGs (Guildford and Waverley, North West Surrey and Surrey Downs) have worked together with Surrey County Council to develop priorities and plans (sometimes known as commissioning intentions) that will achieve our joint ambitions for citizens and stakeholders.

Commissioning intentions describe how we would like our service providers to shape their services to meet:

- The local health and care needs of our populations
- The national priorities for the NHS as outlined by NHS England in the Five Year Forward View.

The health and care needs of our populations are summarised in the Joint Strategic Needs Assessment (JSNA), a live document covering Surrey that is continuously updated, and in the local health and care profiles for each CCG area.

Commissioning intentions are agreed and published on a yearly basis in April.

Ongoing involvement and engagement with stakeholders

The CCGs and Surrey County Council engage with a wide range of stakeholders throughout the year to review and develop their commissioning intentions. Provision can be made to accomodate emerging national and local requirements during the year. This is known as a commissioning cycle.

Our commissioning intentions for 2018-19 have been designed to help deliver the following Surrey Heartlands' objectives:

- Improve health and social care outcomes
- Drive integration of services and functions that improve quality and reduce health inequalities
- Increase citizen involvement in decision-making
- Demonstrate public value
- Standardise best practice in health and social care through commissioning and provision, to secure improved outcomes, efficiencies and effectiveness
- Achieve sustainable financial balance

Our devolution agreement

All commissioning responsibilities for the Surrey Heartlands population, subject to agreement with the relevant national bodies, could come under the scope of our new devolution agreement beginning in April 2018 (and currently in shadow form).

This ground-breaking plan means funding (for both health and social care) currently held at regional and national level could be devolved locally. This would give us more control in how this funding is used, meaning we can address the specific needs of our population. It would also give us an opportunity to further join up health and social care services.

You can read more about the benefits of devolution at www.surreyheartlands.uk/devolution

Accountable Care System

Surrey Heartlands has been invited to be part of an Accountable Care System development programme. Accountable Care Systems build on local Sustainability and Transformation Partnerships and go a step further, with the aim of creating integrated health systems at a local level. This would see commissioners, providers and local authorities taking on clear, collective responsibility for local resources and the population's health.

Find out more at www.surreyheartlands.uk

Collaborative Commissioning Intentions

These are the services commissioned across the Surrey Heartlands area with the three CCGs often working very closely with Surrey County Council through joint commissioning arrangements.

Surrey County Council's remit includes the provision of adult social care, Public Health (e.g. sexual health, substance misuse, stop smoking and healthy weight) and a wide range of services for children and young people. These services often interlink with NHS services.

Our longer term ambition is to fully integrate these services so that they wrap around the individual and their families.

Contents

Other enabling elements are being developed through the Surrey Heartlands transformation plan, including digital transformation, making most effective use of public sector estates and ensuring there is a sufficient and capable workforce.

Children and young people

Health needs

- Surrey's population of children and young people (CYP) aged 5 to 14 years old is experiencing the biggest increase in population
- 5 out of every 30 pupils Special Educational Needs
- More than 1 in 4 children aged 10-11 are overweight or obese
- In 2011, 3% of children under 16 (6,330) had day-to-day activities limited by a long term health problem or disability
- It is estimated that 10,600 of 5 to 15 year olds have a mental health disorder
- In March 2013, there were 830 Looked After Children (LAC); 550 had been looked after for at least 12 months
- 70% of LAC aged 4 and above have Special Educational Needs whilst immunisations were up to date for just 62% of LAC

Our plans

- Provide the right early support to promote good emotional wellbeing, physical and mental health and prevent problems escalating by identifying issues early and ensuring children, young people and families needing extra help receive timely, preventative support
- Ensuring women are able to make safe and appropriate choices of maternity care for them and their babies
- Provide a positive experience of Special Educational Needs and Disability (SEND) services and support for children, young people and families and provide educational opportunities for children and young people with SEND in local schools or colleges that offer the best value
- Improve the health of children and young people (CYP) with a learning disability

- Continue to support children with complex needs including further development of our offer in regard to personal health budgets, encouraging an increase in uptake
- Provide placements or accommodation for looked after children, care leavers and unaccompanied asylum-seeking children that are appropriate, local and that provide value for money
- Improve access to health services and improve the health outcomes of children in care and those recently adopted
- Ensure that there is a clear pathway for young people entering care and for when they transition into adult services
- Prevent and reduce the impact of child sexual exploitation and children who go missing from home and care
- Prevent and reduce the impact of abuse (including domestic abuse) and neglect
- Increase school readiness, educational achievement and health outcomes in those disadvantaged groups

- Increase participation in education, training and employment post 16 for children and young people in our 'vulnerable groups'
- Support CYP and their families to have good mental and physical wellbeing, including:
  - Review provision of weight management programmes for very young and families with the potential scope to integrate current services and extend service provision
  - Embed recently re-modelled services for Sexual Health, Integrated Substance Misuse and Stop Smoking
  - Continue to improve delivery of Community Health Services
- Deliver the national priorities as well as those of the Surrey Safeguarding Boards for children

For more detail and a further description of each of these commissioning intentions please visit Child First, Commissioning Intentions for Children in Surrey on the Surrey County Council website.

Mental health and wellbeing (adults)

Health needs

- Not enough people with mental health problems are receiving treatment because they have not come to the attention of services that can help.
- Not enough people with a serious mental illness are receiving a Physical Health Check in primary care, affecting their overall life expectancy.
- Perinatal mental health illness is the leading cause of death for women during pregnancy and in the one year after childbirth.
- One fifth of our population is aged over 65 and this proportion is increasing. This means that an increasing proportion of the population will be suffering with dementia, depression and long term conditions requiring psychological care.

Our plans

Robust crisis intervention and support

- Create a single point of access for crisis and overnight support, 24 hours a day, 7 days a week and ensure crisis plans are high quality
- Agree the business case for 24/7 mental health inpatient care service with stakeholders
- Continuously monitor Safe Havens to ensure they enhance the mental health crisis pathway
- With partners, implement the core standards for high quality 24/7 acute psychiatric liaison services from April 2018

A good start for mother and baby

- Develop a Surrey Heartlands specialist community perinatal mental health service to care for women who experience mental ill health during pregnancy and/or in the first year following the birth of a child (benefits mother and baby)

Treating the whole person through holistic care

- Ensure people with complex and ongoing care needs can easily access mental health expertise through existing integrated teams
- Enhance primary care, urgent and emergency care with new forms of mental health support to better equip teams to meet physical and mental health needs of individual patients
- Integrate delivery of psychological therapy with services caring for people with long term conditions and pilot embedded employment advisors in these services (IAPT)
- Inform providers whether procurement of a Mental Health Citizens Advice Service will occur

Suicide prevention

- Increase the number of GPs and hospital staff who have received suicide prevention training
- Continue to work on anti-stigma / time to change along with suicide prevention and mental health training
- Reduce the suicide rate by more than the 10% national target

Care for people with dementia and their carers

- Increase early diagnosis of dementia and work towards patients being treated within 6 weeks of referral through implementation of a Surrey-wide Dementia Strategy
- Provide more dementia support in primary care settings instead of in hospital

People with learning disabilities (children, young people and adults)

Health needs

- In Surrey, 20,463 adults are estimated to have a learning disability of whom 3,891 are aged 65 and over (2012)
- 40% of parents caring for a son or daughter with a learning disability are over the age of 60
- A number of barriers to accessing healthcare services have been identified and include:
  - Physical barriers
  - 'Reasonable adjustments' not being made to overcome literacy and communication difficulties that people with learning disabilities may experience

- ‘Diagnostic overshadowing’ whereby a person’s physical symptoms are mistakenly attribute to the person’s mental health/behavioural problem

- Death rates for people with moderate to severe learning disabilities are three times higher than that of the general population whilst certain conditions e.g. early onset dementia, epilepsy, mental illness and sensory loss are more common

Our plans

A better understanding of those we care for

- Analyse in more depth the exact nature of health conditions and health inequalities experienced by people living in our area who have learning disabilities to better inform our service planning

Working towards equity of care

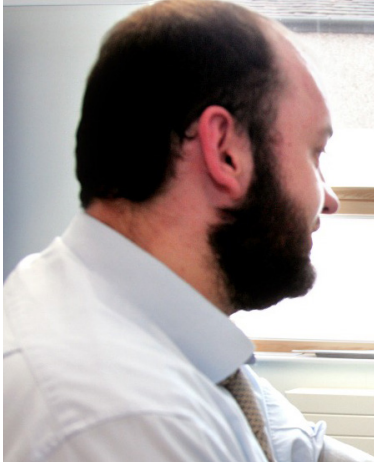
- Increase the number of people with learning disability being screened for cancer
- Develop early baseline assessments for dementia to enable timely diagnosis leading to robust clinical support
- Encourage uptake of the GP Annual Health checks and Health Action Plans at Transition for Young People aged 14 years+

Intensive, high quality support and rehabilitation in the community

- Provide support to people with autism and challenging behaviour closer to home through Intensive Support Teams
- Develop intensive multi-agency wraparound support and crisis response teams in the community
- Reduce inpatient admissions to low/medium secure facilities and assessment or treatment units in the community by delivering multi-agency care closer to home
- Develop intensive specialist support to ensure complex patients are discharged and rehabilitated in the community, with the right support

Continuous learning to improve safety and quality of care

- Review the death of every person with a learning disability in line with the Learning Disability Mortality Review programme



Carers (young carers and adults)

Health needs

- Based on the 2011 census and population projections, it is estimated that in 2016 there were 115,216 carers of all ages living in Surrey.
- Overall, 44% of young carers and young adult carers known to services are caring for someone under the age of 18.
- 32% of young carers under the age of 8 are caring for an adult (2017; Surrey Young Carers).
- The impact of caring can be detrimental to carers health owing to a number of factors, including stress-related illness or physical injury.

Our plans

- We will continue to commission the following services, known as our 'universal offer':
  - Adult carers support
  - Young and young adult carers support
  - Giving carers a voice
  - Manual handling
  - Benefits advice for carers
  - Carers direct payments (Carers' Breaks)
  - Home based care flexible breaks
  - End of life carers support
  - Healios – supporting carers' mental health

Safeguarding (children and adults)

Health needs

- Any child or young person can be at risk of neglect, abuse, harm and exploitation regardless of their age, gender, socio-economic or ethnic background.
- Adults at risk include people who are frail due to a combination of factors; those who have a learning disability and/or a sensory impairment and those are unable to demonstrate the capacity to make a decision and are in need of care and support.
- Safeguarding requires a multi-agency approach.
- Surrey Safeguarding Children Board
- Surrey Safeguarding Adults Board

Our plans

- Deliver the national priorities as well as those of the Surrey Safeguarding Boards for children and adults
- Ensure that there are robust systems and processes in place that protect and safeguard vulnerable children adults
- Support the running of the Multi-Agency Safeguarding Hub (MASH)

Adult social care

Health needs

- Adult Social Care has a statutory responsibility under the Care Act 2014. This means local authorities are responsible for promoting people's wellbeing, focusing on prevention and providing a universal information and advice service.
- Surrey County Council meet these responsibilities by promoting people's independence and wellbeing through personalised care and support and by working collaboratively with partners to enable people to stay well, safe and independent. When this is no longer the best option, we want people to understand their choices.

Our plans

- Actively work to deliver the best options for accommodation with care and support to Surrey residents
- Develop an integrated approach across health, care and the community, and ensure everyone has access to the right support
- Implement the changes agreed as part of our recent review of Housing Related Support
- Embed the recently commissioned Home Based Care service
- Explore collaborative working opportunities and embrace the use of technology in care
- Review options for equipment and adaptations services
- Develop the future approach for a range of services including Dementia Navigators, Home from Hospital, Stroke, Information and Advice, Benefits Advice, Intermediate Care Team/Re-ablement Integration and Wellbeing Prescription

Emergency and Urgent Care

Health needs

- NHS 111, out-of-hours primary care, 999 emergency ambulance services and the patient transport service are commissioned on a Surrey-wide basis whilst emergency care in hospitals (acute trusts) is commissioned on a local basis by each CCG.
- Demand for all emergency and urgent care services is increasing each year whilst there are unprecedented financial, capacity and workforce challenges requiring the collaborative delivery of transformation plans and system efficiencies.

Our plans

Prompt and accessible advice and care when needed

- We plan to commission a new integrated urgent care service to provide treatment and clinical advice. This new service, planned to 'go live' in April 2019, will integrate the current NHS 111 and Out of Hours primary care service. It will include a clinical assessment service along with the face to face treatment provision during evening and weekends
    - Following engagement, the restricted tender process is due to commence in January 2018

Optimise the ambulance service

- Provide and maintain a safe and responsive service and focus on key areas of risk to minimise long waits
- Develop alternatives to Accident & Emergency pathways to relieve pressure in the system e.g. treating patients at home (See & Treat)
- Invest in a joint Demand and Capacity Review to better inform commissioning of a new model of emergency 999 care and to support delivery of the Ambulance Response Programme (ARP)
- Implement the ARP to increase operational efficiency and improve focus on clinical need and outcomes, making best use of resources and workforce
- Apply policies to improve the handling of surges in demand for ambulances to maintain quality and safety
- Work with providers to reduce the time taken to hand over the care of patients from paramedics to emergency department teams in hospitals

Explore how complementary services could support and enhance urgent care provision

- Explore how non-urgent Patient Transport Services (PTS) can safely support the following:
  - the provision of care out of hospital
  - the 999 service (Health Care Professional activity)

Easing discharge of patients to help provide hospital care for those who need it

- Explore opportunities to support the 'discharge to assess' model of care with provider partners whereby funding is not a barrier to getting the right care in the right place at the right time

NHS Continuing Healthcare

Health needs

- NHS continuing healthcare (CHC) is a package of on-going care that is arranged and funded solely by the NHS. It is designed to support individuals aged 18 or over who are found to have a primary health need which has arisen as a result of disability, accident or illness.
- It can be provided in a variety of setting outside hospital, such as in the home or in a registered care home.
- NHS CHC is for adults.
- Children and young people may receive a "continuing care package" if they have needs arising from disability, accident or illness that can't be met by existing universal or specialist services alone.

Our plans

Safety, dignity and quality of care

- Ensure high quality care is provided throughout, including End of Life Care (EoLC)
- Support and incentivise providers to improve management of pressure ulcers, urinary tract infections, nutrition and hydration, falls prevention, flu vaccination and proactive and safe discharge

Providing the right care at the right time through integrated working and other efficiencies

- Expand Personal Health and Integrated Personal Budgets for CHC clients
- Work with local partners to address the pressures in the system that can delay appropriate care being delivered
- Improve delivery of home and domiciliary care
- Deliver contract improvements for individual packages of care to deliver better value and outcomes for individual patients
- Develop partnerships for integrated health and social care commissioning of local services


QUICK

Medicines

Health needs

- The use of medicines is the most common type of treatment for therapeutic intervention of medical problems
- It is estimated that 15 to 20% of a CCG's budget is spent on medicines
- It is therefore important that all aspects of supply, use and disposal of medicines are regularly reviewed
- Each CCG has a Medicines Management Team; all three teams across Surrey Heartlands' CCGs work collaboratively to ensure medicines are optimally used by prescribers and patients alike

Our plans

Make sure medicines are being used to best effect

- Increase the number of medication reviews to improve care and ensure that medicines are prescribed in a way that reduces medicines waste
- Provide support to help manage anticoagulation of patients with Atrial Fibrillation to reduce the risk of a stroke
- Ensure that antibiotics are used appropriately to help minimise antibiotic resistance
- Optimise use of stoma and continence products
- Support the implementation of recommendations to be made by NHS England in relation to medicines which should not be routinely prescribed in primary care

A more efficient hospital pharmacy service with robust links to primary care

- Optimise the use of hospital pharmacies in accordance with recommendations to improve efficiency made in the Carter Review (Hospital Pharmacy Transformation Programme)
- Improve the standard of outpatient letters and the transfer of patient medication information between primary and hospital care at the admission and discharge stage
- Implement a Trust Repeat Dispensing Scheme across our providers

Enable community pharmacies to play more of a role in our overall care system

- Improve links with community pharmacy to focus on prevention and provide more health care closer to home


RESCRIPTIO
prescriptions
delivery ser
alli
SlimFast
Snacks
Crafe Away

Local Commissioning Intentions

Surrey Heartlands' CCGs want people living in our local areas to be able to access the right care in the right place at the right time; being able to get an appointment at your GP practice; being able to see a specialist nearer to where you live or work or being able to be discharged from hospital, with the right support, when you are ready to return home. These are just some of the issues that we want to tackle and improve.

Above all, we want our local health and care system to respond to your health needs and make the best use of available resources. We know that a local approach that meets local health needs is important and this section summarises our more local plans by area.

Through local commissioning arrangements with providers, each CCG will improve the following areas of care.

Cancer care

- Work together to implement the NHS' national cancer strategy and improve cancer care
- Continue our work on early detection of cancer and improving screening uptake
- Improve the quality and effectiveness of care and support to those living with, and beyond, cancer

Diabetes care

- Increase uptake of structured education for newly-diagnosed patients to improve people's confidence and give them skills to help them manage their diabetes, which can reduce complications
- Develop the role of Inpatient Specialist Nurses for patients with diabetes
- Increase the number of patients who are achieving the three treatment targets in blood glucose (HbA1c), blood pressure and cholesterol

Stroke care

- Continue to work with providers to improve stroke care, ensuring that stroke care is provided in line with the South East Coast Stroke Services Specification. Improvements include:
    - Increased consultant cover, improved outcomes, increased thrombolysis and faster access to specialist advice, increased community support

The following pages have the plans that each CCG will particularly focus on in 2018/19 to improve provision of primary care, planned care, out of hospital care and emergency care.

NHS
Guildford and Waverley
Clinical Commissioning Group

Our plans

Primary care

- Roll out the provision of GP appointments in evenings and at weekends (known as extended access) to 100% of the population by September 2019 through collaborative working between practices, allowing direct booking of GP appointments and future integrated compatibility with NHS 111
- Further develop locally commissioned services in primary care. This includes
  - additional incentives for GPs to support diabetes structured education as well as increasing the utilisation of spirometry and ECGs within primary care

- Implement the commitments made in the GP Forward View document, published in April 2016. This includes:
  - expanding current training of primary care administration staff to undertake care navigation and signposting roles
  - supporting with new IT projects led by interested GPs
  - continuing with our Clinical Leadership programme
  - supporting practice managers to maximise productivity through sharing of best practice and policies.
- Seek to establish delegated or co-commissioning whereby the CCG would take on more responsibility for the commissioning of primary care services. This would allow greater involvement of patients in shaping services and ensure equity of access to primary care for our population.

Planned care

- Develop local services in GP practices that utilise the skills of a range of health care professionals to enable more patients to be cared for closer to home.
- Enhance the use of the Advice and Guidance service whereby GPs can formally request expert input from consultants using electronic means to inform next steps of care – this can mean that patients can often access rapid reassurance on test results or next steps in their treatment, without having a longer wait for a hospital appointment.
- Develop systems that empower patients to make shared decisions and initiate their own follow-up care.

Out of hospital care

- Deliver the integrated approach to adult community services as committed to through their re-procurement in 2017/18, using Proactive, Intermediate and Place Based Care models
- Formalise locality working to allow GP practices to work together on a range of different initiatives that improve access to expert care closer to home e.g. to provide additional primary care appointments in a range of different locations, working out which are most accessible and offer the best experience for patients.
- Accelerate the development of the GP Federation, which will support the voice of primary care in the development of integrated pathways between acute and community, an increase in the potential for delivering more clinics in local practices and managing patients in primary care with the necessary resource and capacity to do so

Urgent and emergency care

- Develop options for the provision of community-based urgent care that integrates with local services and meets the requirements of NHS England
- Carry out an in-depth review of how our community hospitals operate, following the initial review carried out in 2016/17
- Ensure that the Directory of Services used to support improved use of more suitable alternatives to A&E is robustly updated by out of hours service providers
- Develop a 'virtual team' that supports the in-reach GP (based in the hospital) that works to avoid patients being admitted to hospital
- Establish an integrated pathway that enables the proactive management of patients who are ready to be discharged from hospital, to include the use of discharge to assess

NHS
North West Surrey
Clinical Commissioning Group

Our plans

Primary care

- Roll out extended access (evenings and weekends) using NHS 111 and direct booking of GP appointments
- Explore the expansion of locally commissioned services in primary care to ensure high quality care can be delivered in a primary care setting wherever possible
- Facilitate locality working to allow GP practices to work together via the Locality Transformation Scheme (LTS)

Planned care

- Redesign treatment pathways for key specialities such as diabetes, cardiology, respiratory and catheter/continence care
- Support the mobilisation of sexual health and HIV services commissioned by Public Health and NHS England
- Continue developing virtual clinics for specialities such as fracture clinic and some surgical and cancer disciplines
- Review the provision of diagnostic testing to ensure overall patient care is optimised across different clinical pathways
- Encourage the uptake of new technologies to improve patient and clinician outcomes via Advice and Guidance services

Out of hospital care

- We are planning a co-design exercise before the end of this financial year on the urgent care and out of hours provision
- Expand Locality Hubs to different geographical treatment locations to meet equality needs
- Develop care provided in care and nursing homes
- Create an Intermediate Care Team to provide support in the community or after admission to hospital

Urgent and emergency care

- Review and improve the provision of urgent care services to include accreditation of Urgent Treatment Centres (UTC) and provision of extended GP services
- Develop a single integrated discharge service to support people following an acute episode of care
- Review the provision of emergency Ambulatory Care (same day emergency care) in acute and community services

Suicide prevention

- Recent published figures show that the mortality rate from suicide is higher in North West Surrey than the England and the Surrey Heartlands' average. Local work will take place with Surrey Public Health to develop a plan that looks to reduce this by a higher percentage than the national 10% target.

NHS
Surrey Downs
Clinical Commissioning Group

Our plans

Primary care

- Roll out extended access (GP appointments at evenings and weekends) to include pre-bookable and urgent appointments
- Implement the national GP Forward View, which includes working with practices to address workforce, IT and estates issues
- Facilitate locality working to allow GP practices to work together to deliver local services at scale
- Continue to explore delegated or co-commissioning, which could see the CCG taking on responsibility for commissioning core GP services

Planned care

- Continue to implement our plans to improve musculoskeletal care, working across Surrey Heartlands to identify opportunities to deliver improvements across a larger population
- Expand the scope of our current tele-dermoscopy service to include other symptoms (including rashes)
- Continue to deliver improvements in eye care pathways, with a wider range of services available in community settings
- Complete the procurement of adult audiology services and launch the new service
- Review urology, radiology, gynaecology and ultrasound diagnostic services to identify opportunities to improve care

- Continue to implement new Advice and Guidance services for GPs so they have direct access to colleagues in secondary and community care for specialist advice before referring patients
- Continue to develop community cardiology pathways, working with Surrey Heartlands partners to deliver improvements at scale

Out of hospital care

- Engage locally on out of hospital programmes being led by Surrey Heartlands, that will see wider range of services provided in community settings
- Expand our Community Hubs, which help identify people at risk of hospital admission and provide targeted support

Urgent and emergency care

- Further integrate and develop adult community services to support our localities
- Expand the Community Hub model of care to better care for at risk patients and support patient activation
- Continue implementation of Shared Care Plans, where consent has been given, to improve care and help initiate proactive treatment
- Review how urgent care is provided in acute and community settings and find ways to assess, diagnose and treat more patients so they can go home on the same day, without needing to be admitted to hospital (sometimes known as 'ambulatory care')
- Continue to work with Epsom and St Helier and colleagues in south west London as part of the next stage of work that is looking at how some specialist acute services could be provided in future.

Next steps

How our Commissioning Intentions are developed

December 2017

Share our draft commissioning intentions with Surrey Health and Wellbeing Board

17 January to 18 February 2018

Patient, public and stakeholder engagement

February to March 2018

Analyse findings, write outcome report and review our draft intentions in light of feedback received

April 2018

Sign off final intentions at our Governing Body meetings (each CCG) and publish them online

Have your say

The three Surrey Heartlands CCGs and Surrey County Council want to find out what patients, carers, the public and other key stakeholders think about our shared commissioning plans for 2018/19.

Have your say using the following mechanisms.

Online Survey

Open from 17 January 2018 to 18 February 2018

www.surreysays.co.uk/deputy-ceo/commissioning

Complete survey by hand

Printed copies of this booklet and the survey are available by contacting NHS Guildford and Waverley CCG using the details on the back cover of this booklet. You can also send a written request to:

FREEPOST
NHS G&W CCG

The outcomes of this survey will be analysed to inform the final review of our joint commissioning intentions before they are approved by the CCGs' Governing Bodies in March/April 2018. The final commissioning intentions will be published in April 2018.

Glossary

A&E Accident and Emergency

An A&E department (also known as emergency department or casualty) deals with genuine life-threatening emergencies.

ACS Accountable Care System

Local NHS organisations, often in partnership with local authorities, working together as an integrated system, having collective responsibility for resources and the health of its population.

ARP Ambulance Response Programme

New ways of working to deliver a modern and responsive ambulance service in England.

Ambulatory Care

The provision of safe, patient focused and flexible, same day emergency treatment for appropriate patients that aims to prevent unnecessary hospital admissions.

CCG Clinical Commissioning Group

Commission most of the hospital and community NHS services in the local areas for which they are responsible.

CHC Continuing Health Care

Also known as ‘fully funded NHS care’, CHC is free care outside of hospital that is arranged and funded by the NHS.

Commissioning

Involves deciding what services are needed for diverse local populations, and monitoring how they are provided.

Commissioning Intentions

Sets out the health and social care services to be bought/ provided and the health outcomes to be achieved for the local population in a specific timeframe.

CYP Children and Young People

People who are 18 years old and under.

Devolution

The transfer or delegation of power to a lower level, especially by central government to local or regional administration.

EoLC End of Life Care

Support for people who are in the last months or years of their life. End of life care should help you to live as well as possible until you die, and to die with dignity.

FYFV Five Year Forward View

A plan to deliver a more responsive NHS in England, focussed on the issues which matter most to the public, so that it can continue to deliver health and high quality care – now and for future generations.

GP **General Practitioner**

GPs deal with a whole range of health problems. They also provide health education, offer advice on smoking and diet, run clinics, give vaccinations and carry out simple surgical operations.

GP Federation

Also known as a Primary Care federation. A formal or informal alliance of General Practices and other community Primary Care providers who work together to achieve and deliver a range of objectives.

JSNA **Joint Strategic Needs Assessment**

An assessment of the current and future health and social care needs of the local community.

LTS **Locality Transformation Scheme**

GP practices working together to provide an opportunity to access a range of health, social care and community services all in one place.

MASH **Multi-Agency Safeguarding Hub**

A team of multi-disciplinary professionals from partner agencies (social workers, police, health) working together to deal with the safety or wellbeing of a child.

NHS **National Health Service**

The publicly funded national healthcare system for England.

Primary Care

The first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

SEND **Special Educational Needs and Disability**

Children who have learning difficulties or disabilities that makes it harder for them to learn than most children and young people of the same age. These children and young people may need extra or different help to others.

UTC **Urgent Treatment Centres**

These will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for.

Contact us

NHS Guildford and Waverley CCG

Dominion House, Woodbridge Road, Guildford, GU1 4PU

01483 405450

07827 663749

www.guildfordandwaverleyccg.nhs.uk

gwccg.info@nhs.net

NhsGuildfordAndWaverleyCcg

@NHSGWCCG

NHS North West Surrey CCG

58 Church Street, Weybridge, Surrey, KT13 8DP

01372 232400

07880 091328

www.nwsurreyccg.nhs.uk

contactus.nwsurreyccg@nhs.net

NWSurreyCCG

@NWSurreyCCG

NHS Surrey Downs CCG

Cedar Court, Guildford Road, Leatherhead, Surrey, KT22 9AE

01372 201500

07747 476511

www.surreydownsccg.nhs.uk

contactus.surreydownsccg@nhs.net

surreydownsccg

@SurreyDownsCCG

Surrey County Council

County Hall, Penrhyn Road, Kingston upon Thames, KT1 2DN

03456 009 009

07860 053 465

www.surreycc.gov.uk

public.health@surreycc.gov.uk

surreymatters

@HealthySurrey

This booklet is also available on request as a paper copy, including in large print.

Designed by NHS Guildford and Waverley CCG v3.4 January 2018