Democratic Services

To: All Members of the Health Liaison Panel

Dear Councillor,

HEALTH LIAISON PANEL - TUESDAY, 11TH JULY, 2023 , Council Chamber - Epsom Town Hall

Please find attached the following document(s) for the meeting of the Health Liaison Panel to be held on Tuesday, 11th July, 2023.

4. **SURREY HEARTLANDS SERVICE UPDATE – SURREY DOWNS HEALTH & CARE PARTNERSHIP PRESENTATION SLIDES** (Pages 3 - 12)

For further information, please contact democraticservices@epsom-ewell.gov.uk or tel: 01372 732000

Yours sincerely

Chief Executive

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SURREY DOWNS
Health & Care Partnership

Epsom and Ewell Health Liaison Panel
Tuesday, 11th Jul 2023

Surrey Downs Health and Care Partnership (place)

SDHC place

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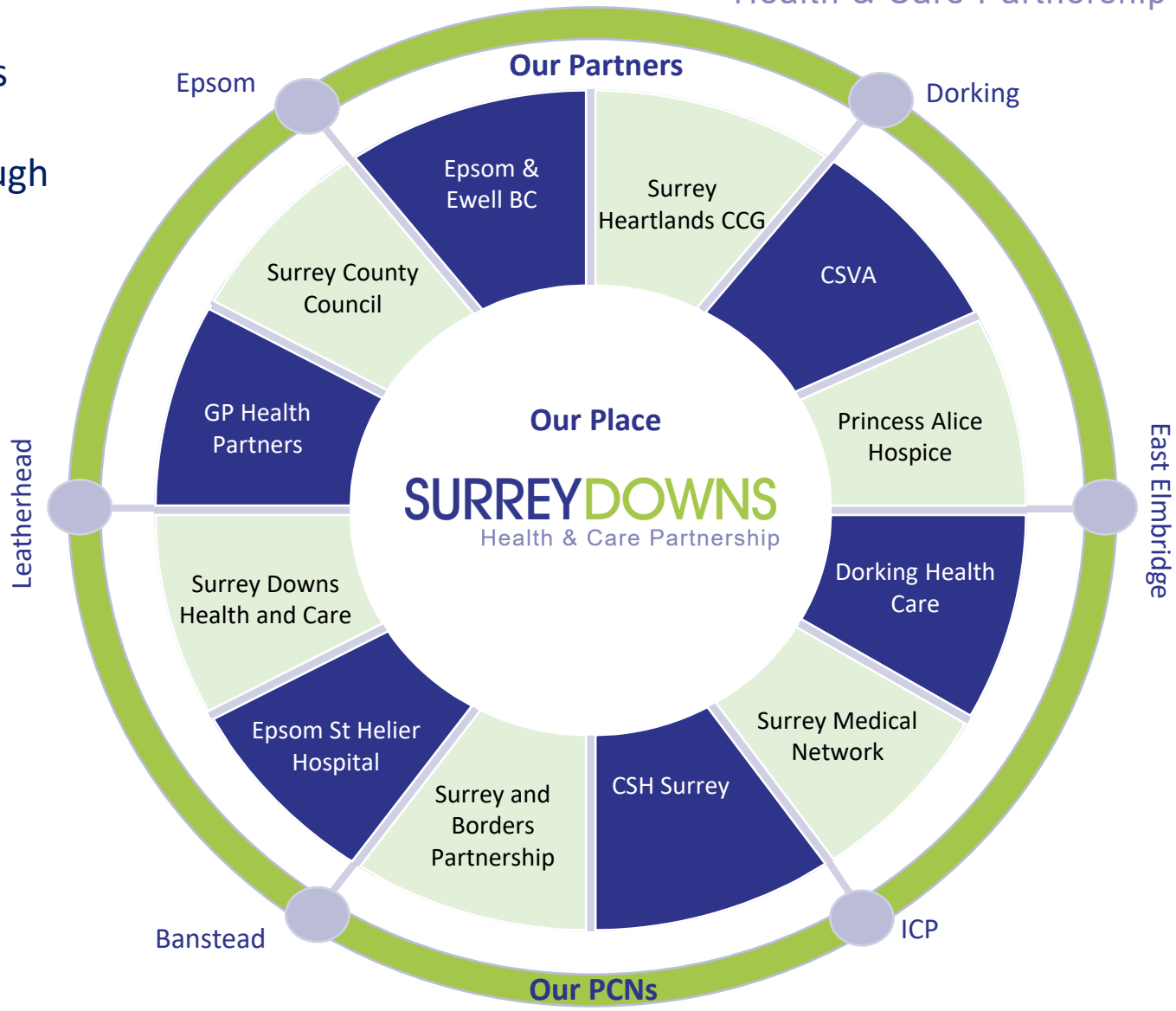
Our ambition is to create a health and care system that is built around the people and communities of Dorking, Epsom and East Elmbridge, and continually evolves through collaboration between local providers

- We have an **established track record of working in partnership**
- We **know our local population**; we **understand their needs**; and have put **in place the foundations of a strong collaboration.**
- We have a **plan to address health inequalities** through **population health management and thriving community programme**
- **We have strengthened our governance**, developed our organisation structure but most importantly **continued to deliver change through collaborative working**



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Service Developments

Surrey Downs Urgent Integrated Services

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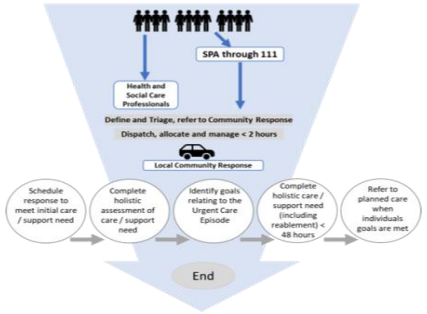
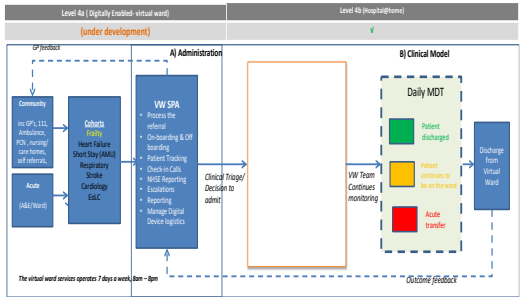
Surrey downs' place-wide urgent care services have been redesigned through workshops with Place stakeholders. These integrated services deliver support across neighborhood boundaries and are underpinned by a central coordination centre to ensure patients receive joined up care.

Locality UCR Service



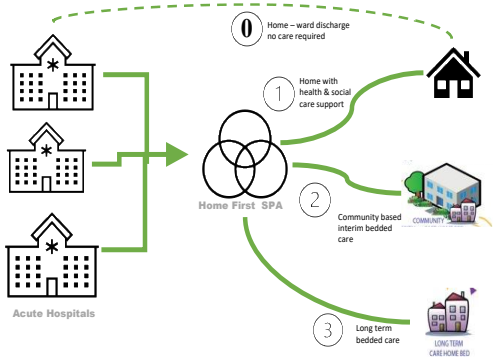
- **Codesigned model** - Model of care has been codesigned by clinicians and stakeholders across the system.
- **Delivered at locality/neighbourhood level** – Model devolved to PCN/locality teams for delivery of local neighbourhood care
- **Full UCR coverage across SD –** service live and supporting over 340 patients a month

Integrated Virtual Ward



- **Integrated team –** Consisting of Consultants GPs, nurses physios pharmacists and rehab workers
- **8-8 Medical Oversight –** Ensuring most complex patients have GP/ Consultant support and senior decision making
- **Overlays UCR teams –** enabling a step up step down support offering for acute and neighbourhood teams

Homefirst

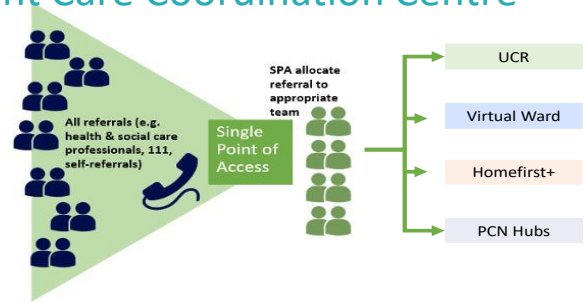


- **Homefirst Hub – Integrated h**ealth and care teams collocated in shared offices with an integrated leadership structure.
- **Integrated huddles** - Held throughout the day to maintain oversight of patients supported out of hospital
- **Recovery @home –** Integrated care function run by the service enhancing care capacity and supporting place wide capacity oversight

Urgent Care Front Door

- **Streaming Redirection –** Embedded pathways to stream and redirect patients to the most appropriate team or service
- **Community "Front Door" Input – C**ommunity services based at Epsom hospital screening patients at front door to assess need, avoid admissions wherever possible

Urgent Care Coordination Centre



- **Single point of access –** For all referrals to place based Urgent Care services
- **Streamlined pathway** –Support patients and referrer navigate the system
- **Care Coordination –** Provides coordination as patients move between services and through their pathway ensuring continuity of care

Surrey Downs Whole System Frailty Model

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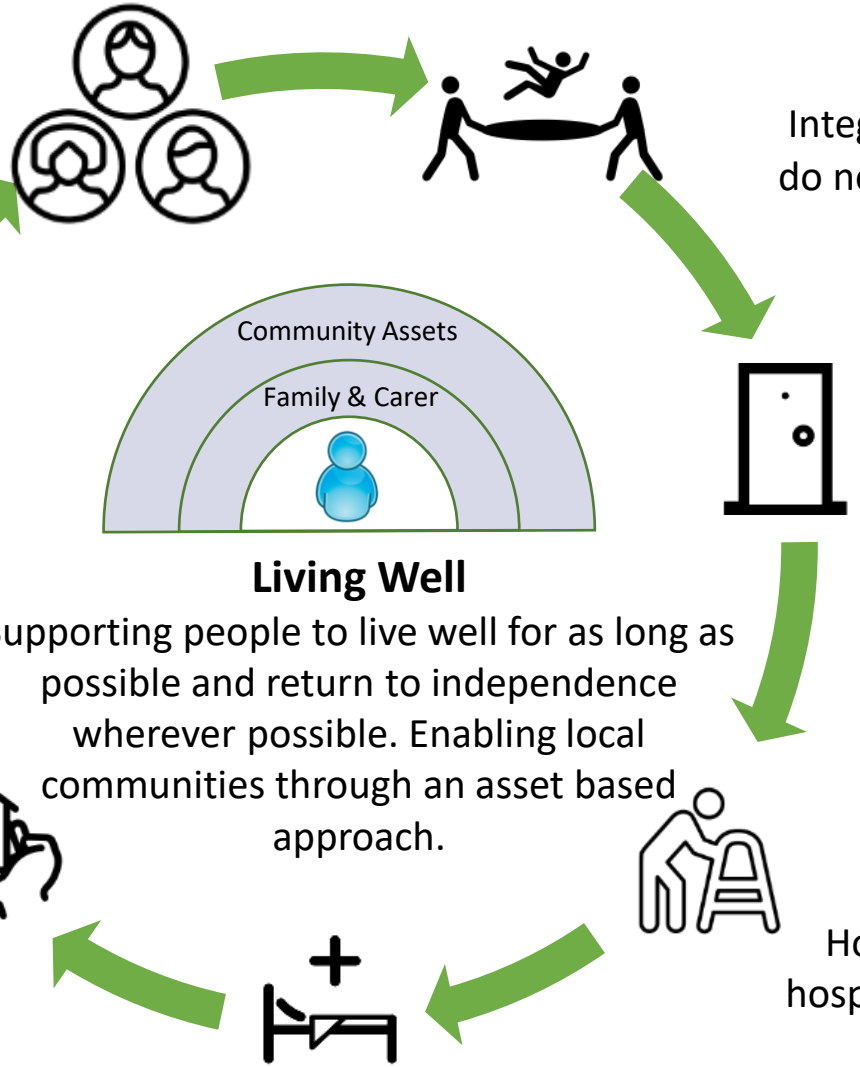

Proactive PCN MDTs
Proactive identification of frailty and comprehensive assessment in partnership with neighbourhood teams to better support people in the community.

@Home UCR
Integrated crisis response for people do not have acute medical needs but are at risk of admission.

@Home Front Door
Community facing frailty team, screening patients at front door to assess need, avoid admissions wherever possible and where admission is required begin discharge planning in ED.

Acute Frailty Pathway
Holistic frailty support throughout hospital journey ensuring continuity of care.

Mary Seacole
Integrated Acute frailty and community rehabilitation unit, providing specialist bedded frailty care and rehabilitation

Home First
Integrated Discharge Function supporting patients home from hospital as soon as medically fit with ongoing assessment in the community.

Virtual Ward
Integrated Virtual Ward consisting of Consultant, GPs and full MDT supporting patients with complex needs at home as an alternative to a hospital stay

Living Well
Supporting people to live well for as long as possible and return to independence wherever possible. Enabling local communities through an asset based approach.

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Community Developments

Pulling Together community programme

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The Surrey Downs Pulling Together programme is focused on asset-based community development, changing the relationship between a place, its citizens, and communities by focusing on 'what's strong, not what's wrong'
The programmes purpose is to bring together two major strands of community and partnership development and PHM to coordinate the co-design within each of our local areas (PCNs and districts and boroughs) of a Health Led Community Driven approach to health and wellbeing.

Over the last 18 months we have: *held a series Pulling Together programme meetings focussed on growing the relationships between our PCNs and local Community partners. As part of this programme we have allocated resource to support delivery of collaborative local projects in each of the 6 PCN footprints in order to;*

- Strengthen relationships between our organisations, and between our organisations and local communities
- Work to better understand the needs, wants and health and wellbeing aspirations of local communities
- Support community-led initiatives to promote health and wellbeing

In addition to the Pulling Together programme meetings, we have held a series of interactive masterclass sessions hosted by Professor Lis Paice designed to support and inspire;

Masterclass 1

This session brought together staff, volunteers and residents from across our system to hear from key note speakers – ***Lord Nigel Crisp, Donna Hall, Sir Chris Ham and Imelda Redmond*** with experience of health and care elsewhere in the UK. Each external speaker was matched with a local speaker who spoke about what is already happening here and what our next steps should be.

Masterclass 2

This session was our first in person event held at Leatherhead Police Federation where we welcomed over ***55 participants from Primary and Secondary Care, local District and Borough and County Council, Food banks, care co-ordinators, voluntary sector and health and wellbeing teams***. Those who attended the session had the opportunity to hear from Professor Lis Paice who opened the session, followed by a truly inspirational presentation from Samira Ben Omar on her experiences of supporting and working with local communities in response to the tragic events of the Grenfell Tower Fire. The final part of the session was led by Neil McGregor-Paterson, Director of Communications, The Health Creation Alliance - during this session members had the opportunity to reflect on the session delivered by Samira Ben Omar and think about their own local communities and the areas they work and what we could start to do differently.

Surrey Downs' Neighbourhoods

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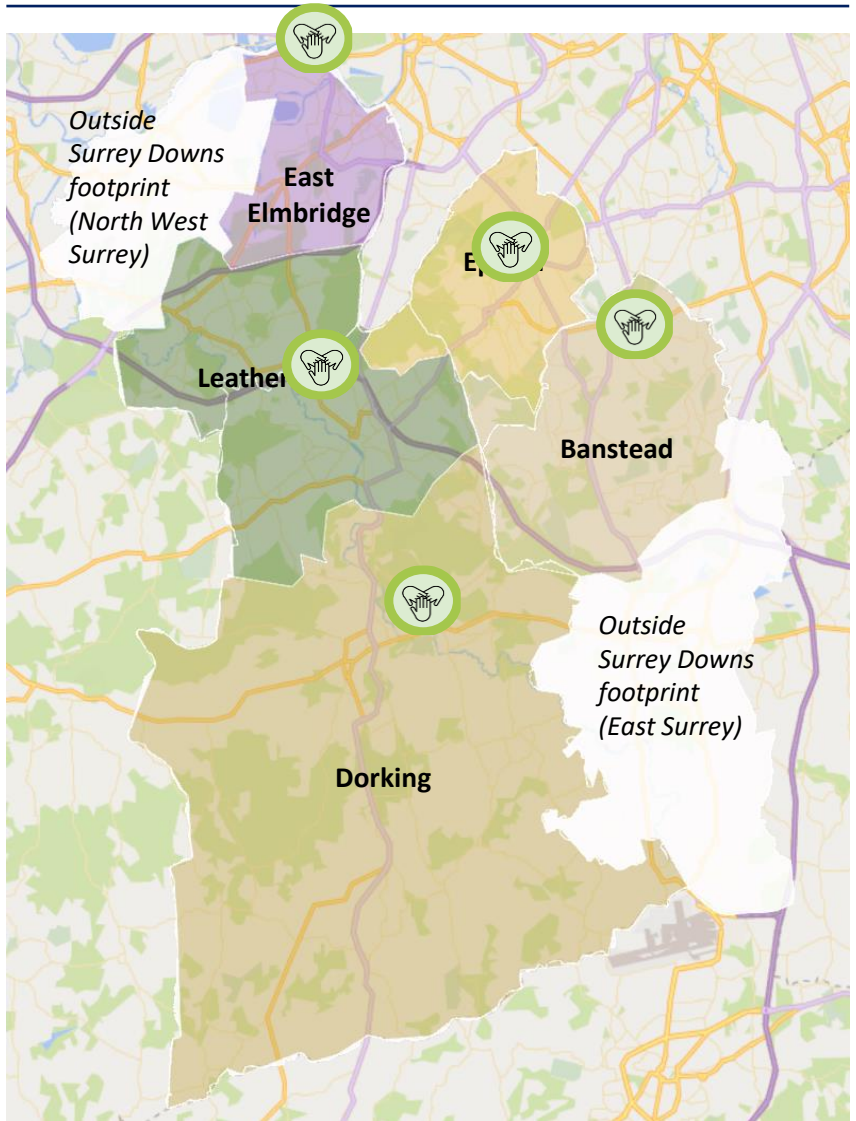
Surrey Downs consists of **six neighbourhoods** which represent communities and geographies that our residents recognise and identify with. Neighbourhoods are developing their own priorities and plans, which underpin our shared overarching place plan.

Integrated Neighbourhood Team (INT)



Neighbourhood Governance

Integrated Neighbourhood Teams (INT)

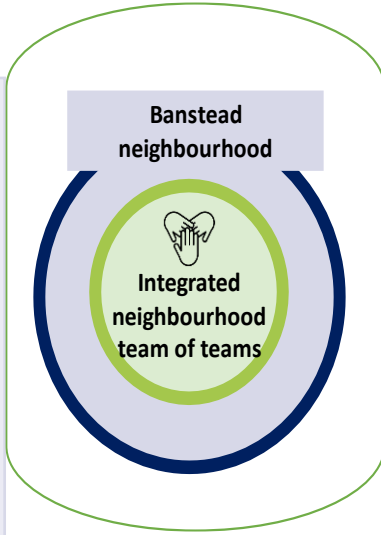
PCNs will be the main **operational delivery vehicle** for local services, and will provide the organising structure for the neighbourhood 'team of teams'.

Neighbourhood

Neighbourhoods will be a **community partnership leading improvements to** population health and wellbeing for local population with alignment to D&B boundaries

Neighbourhood Board

Chaired by the D&B CEO, will be a space for decision making around local developments with D&B and partners, It will oversee investment in local initiatives and track progress



Symbol	Organisational layer	Purpose
	Integrated neighbourhood team of teams (INTT)	• Develop existing MDTs around PCNs to integrate further services • Manage and deliver integrated clinical and operational services • Provide continuity of care and work together to shared outcomes and t improve population health management
Neighbourhood	Neighbourhood	• Lead improvements to population health and wellbeing for local population • Focus on community development, population health management an health creation for the neighbourhood's population (e.g. Pulling Togeth activities) through making better use of shared assets and resources
	Integrated governance board	• Bring together multiple neighbourhoods within the footprint of a distri and borough council to collaborate on community development and health creation across the D&B footprint

Co-designed 'I Statements' – local resident designed outcome measures

Surrey Downs Health and Care Partnership undertook a series of engagement sessions with residents to develop a set of representative I statements that will allow the Partnership to measure its performance delivering the best possible care over time. Sitting underneath these I statements will be a set of outcome metrics that will be used to measure Surrey Downs performance against achieving the expected outcomes for each of the transformation priorities.

Thematic discovery through engagement

Phase 1

- Community engagement **through targeted forums** to understand their current experience of care and what they would like to see in Surrey Downs
- Validation of key themes from community forums using high street **surveys**

Phase 2

I statements	Outcome metrics
Finalise **I statements** based on community priorities for the 4 key areas from survey results and engagement forum discussions	**Prioritise specific metrics** to record progress against I statements from a range of: a) Service activity metrics b) Public Health Fingertips data c) GP survey data d) ONS data e) Other measures i.e. develop resident experience/outcome measures
Benchmarking: E-survey of representative population sample experiences against I statements	

* See appendix for high level options appraisal on this phase

Ongoing monitoring and engagement

Phase 3

Continued community engagement:
- Feedback I statements/metrics

Repeat benchmarking exercise:
- Annual process to track impressions of transformation in a representative sample

Align/collaborate with PHM work:
- Ensure priority metrics align with ongoing work
- Set targets in areas where initiatives are implemented that can be tracked using metrics in dashboard

Work with programme teams:
- Ensure they are aware have input to say which metrics to focus on and enable accountability in demonstrating progress of current and future work

Periodic interviews
- Engagement with selected individuals representing target groups to track improvements and experience over time

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