Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY
COUNTY COUNCIL

NHS

Our Five Year Plan
2019 – 2024

Helping people in Surrey live better and healthier lives

Introduction

In January 2019, NHS England introduced the national NHS Long Term Plan, setting out how the health service will plan and transform services to meet the needs of a growing and ageing population over the next few years.

This document is a summary of how the health and care organisations in Surrey Heartlands will meet the plan locally, as part of our overall 10-year Health and Wellbeing Strategy, to make sure our communities can look forward to a healthier future.

Foreword from Dr Claire Fuller

By 2030 we want to ensure that everyone in Surrey has a great start to life, people live healthy and fulfilling lives and are enabled to achieve their full potential.

We have already begun our journey.

Surrey Heartlands Health and Care Partnership has been working as an Integrated Care System since 2017. This means we have moved away from health and care organisations working in isolation to a real partnership approach, with shared commitments and visions to improve the lives of local people.

The priorities set out in the NHS Long Term Plan fit well with our ambitions and will help us go further faster. However, we know that 80% of the factors that determine good health are not within the control of the NHS and care services. The neighbourhood you grow up in, your home, family and people around you, your schooling, job opportunities and lifestyle choices – all have more impact.

The work we have done with partners to create the Surrey 10-year Health and Wellbeing Strategy focuses on these 'wider determinants of health and prevention', and targets groups of people who generally do less well. By focusing on creating new health and care partnerships – made up of traditional health and care organisations alongside the local Borough Councils and colleagues from the community, voluntary and faith sector – we can make a real difference to the health of local people.

This plan sets out how we intend to make Surrey Heartlands the best place in the country to live and work.

Dr Claire Fuller

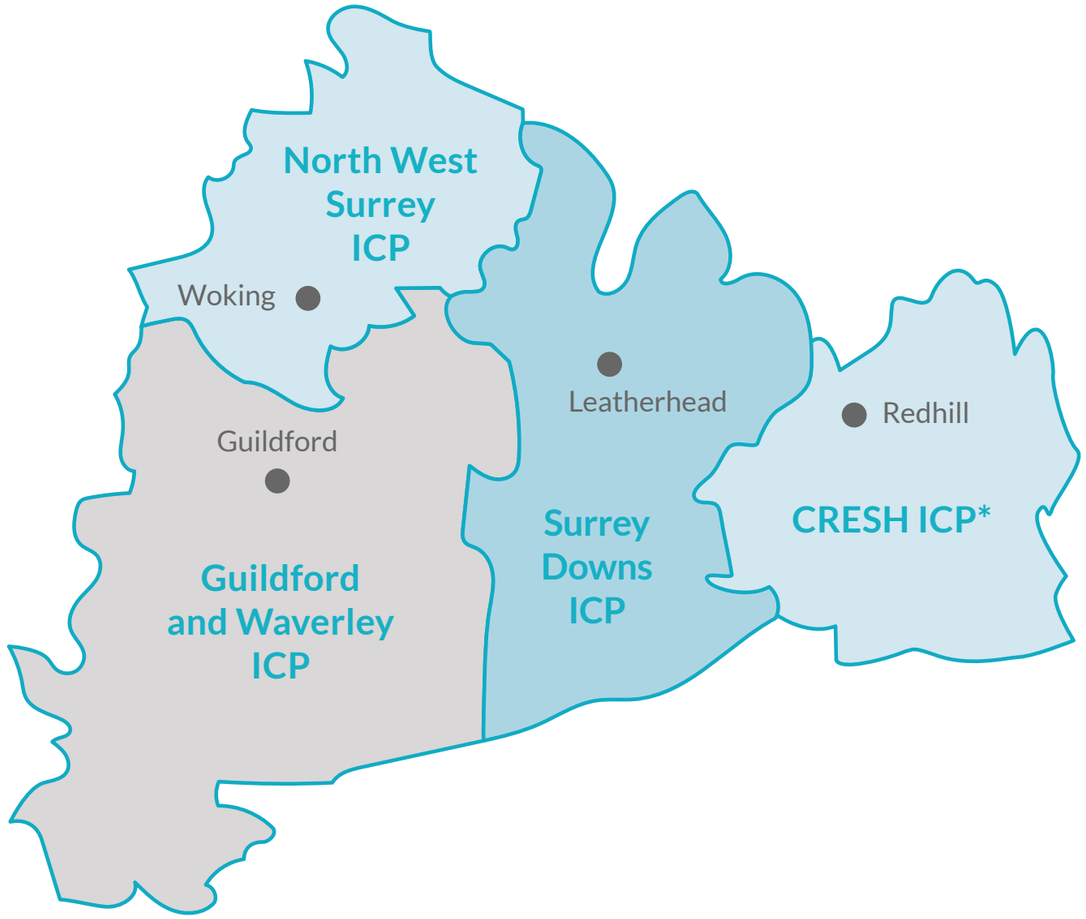
GP and Senior Responsible Officer, Surrey Heartlands

What is Surrey Heartlands?

Surrey Heartlands is an Integrated Care System (ICS). An ICS is where NHS organisations come together with local councils and other key partners to take joint responsibility for managing resources, delivering NHS services and improving the health of the population. We were one of the first group of health and care systems to become an ICS.

Surrey Heartlands represents 85% of the Surrey population, with a combined health budget of over £1.5bn and combined social care and public health budget of £317m.

Because of the size of the area we cover, we have also organised ourselves into four Integrated Care Partnerships to work across more local geographies. These involve local partners including hospitals, ambulance services, GPs, mental health, community services, adult social care, district/borough councils and the community and voluntary sector. These partnerships are able to focus in more detail on local care delivery and are developing their own individual plans to support our ICS-wide priorities.



*Crawley, East Surrey and Horsham

Early achievements

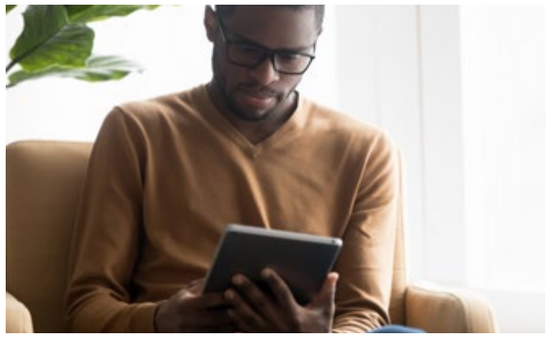
Since our partnership first came together, we've achieved a number of successes that we're really proud of. A few of these are illustrated here.

An award winning 24/7 Maternity Advice line where midwives, located at the ambulance call centre, are able to answer questions from pregnant women and new mums. This has reduced the number of ambulances sent out, has reduced pressure on our maternity wards and most importantly pregnant women have felt much more supported.

Collaborative teams across health and adult social care to improve hospital discharge – for example, Home First at Royal Surrey County Hospital.

Transforming diabetes care services – including new specialist nurses at our hospitals and in the community.

Research using technology – our award-winning dementia study uses cutting edge technology to improve the quality of life for people with dementia living at home.



Piloted online GP consultations allowing patients to speak to GPs who can provide medical advice, prescriptions, fit notes and referrals to help relieve pressure on local GP practices.

Introduced the paediatric HANDI App, an app providing advice and support to parents/carers for symptoms of common childhood illness.

Providing more GP and nurse appointments through the Extended Access Service during the evenings and at the weekend.

A community programme to detect and treat hypertension and atrial fibrillation, both major contributors to strokes and heart attacks.

Established CORE 24 in in St Peter's and the Royal Surrey County hospitals which offers access to mental health services 24 hours a day, seven days a week.

Developed a single point of access for mental health crisis which is being rolled out across Surrey Heartlands.

Set up a new perinatal mental health service from autumn 2018.

Secured £5.6m of funding to transform community mental health services across our Primary Care Networks.

Our devolution agreement

We are taking more of a say over how local services benefit the people of Surrey through a process known as devolution. This means we will have greater control over our budgets and a greater influence in how national decisions are taken that affect our communities.

Our 10-year Health and Wellbeing Strategy

With other partners, we have agreed a **10-year Health and Wellbeing Strategy** for Surrey, which recognises the importance of tackling those other areas that impact on our health and wellbeing – known as the wider determinants of health. Our strategy sets out three key priorities which are all connected, to support people to:

- Lead healthy lives
- Have good mental health and emotional wellbeing
- Fulfil their potential.

Using the life phases of **'Start Well', 'Live Well' and 'Age Well'.**

Start Well

The first five years of a child's life are critical to their future development. Helping children get the best start in life is both good for them and for our society.

Age Well

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by over 18%. It is important to create a health and care system that encourages healthier living so that people can enjoy later life.

Live Well

Most people in Surrey live healthier lives than the average UK citizen; but by focusing on the wider issues that impact our health and wellbeing, such as the environment we live in, we can reduce inequalities in people's health even further.

Developing new ways of working with our partners

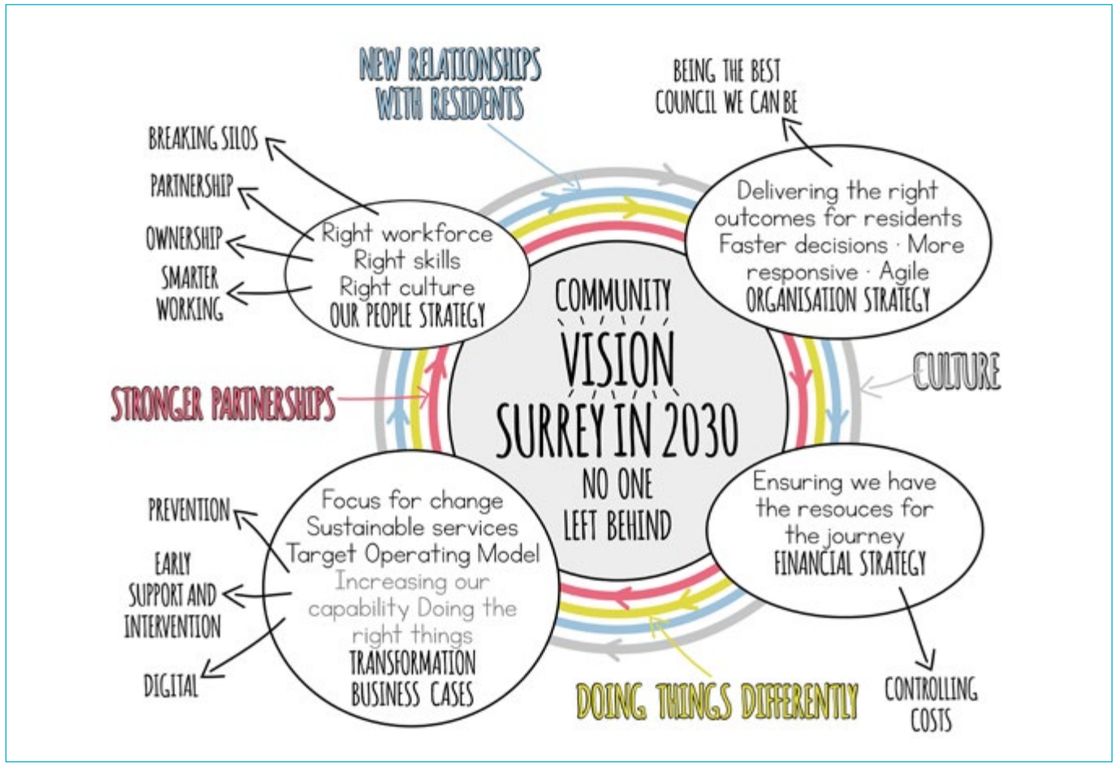
We are working in a new way with local health and care partners, including districts and borough councils, voluntary, faith and community sectors, to make decisions about how we use our joint resources to improve the health of local people.

The local NHS and Surrey County Council are working closely together on areas such as Child and Adolescent Mental Health Services. We already have a number of joint posts and are now appointing joint leaders for important areas such as digital, mental health and children's services to work across our Surrey Heartlands system.

Our ambition to support people in Surrey to live longer healthier lives requires a focus on prevention, addressing the root causes of poor health and wellbeing. Our first devolution agreement, signed in 2017, focused on greater local control of health and care commissioning decisions and bringing responsibilities of the NHS and local government closer together.

The next stage is to achieve even greater integration of services, extending beyond health and social care to include public health, housing, employment and other local services, the wider factors that influence our health and wellbeing. For example, proposals are currently being developed around the devolution of NHS estates in Surrey so we can realise financial benefits that we could invest to improve outcomes for local citizens.

Listening to local people



We want people who live in Surrey to have a real say in the way their health and care services work for them. Through engagement with citizens, communities and partners across the county we have developed an understanding of what Surrey should look like by 2030. Informed by the conversations we had we have been able to create a shared vision for Surrey.

Above all we want our developing plans to be based on genuine, evidence-led citizen and stakeholder engagement to ensure our services meet the needs of local people. To do this, we will:

- Work in a genuine partnership with citizens, patients, local councils and voluntary, community and faith groups.
- Build trust with key partners in our wider system.
- Encourage people to live healthier lifestyles and ensure our local communities understand the services that are available to them.
- Help staff and citizens to make the most of new ways that services can be delivered in the future.
- Celebrate our successes with staff, citizens and stakeholders.

Delivering services for the 21st century

Our new way of delivering services is based on boosting 'out-of-hospital' care and using our Primary Care Networks as the key way to provide more joined up services in local neighbourhoods.

Across Surrey Heartlands we are already providing **more GP appointments at more convenient times, seven days a week**. By working more closely together, practices were able to offer an extra 49,500 appointments last winter (2018).

By 2021, people can expect access to family doctor services between 8am and 8pm, with the option of alternative appointments such as online consultations. We also expect to have **39 trained social prescribing* link workers**, rising to **83** by 2023/24, **supporting over 17,000 people**. We're also aiming to **more than double the use of Personal Health Budgets**, where eligible patients take greater control of their NHS spending by 2023/24.

*Social prescribing is a way of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services that meet their needs in a better way.

What is a primary care network?

To meet the needs of a growing population and make sure it's easier for people to get appointments when they want them, GP practices are working together - along with local community, mental health, social care, pharmacy, hospital and voluntary services - in 'primary care networks'. Working together means they can have bigger teams of staff, including GPs, nurses, pharmacists and they can stay open for longer. It also means patients have better access to specialists and other services.

We're designing new outpatient services to meet the needs of local people. By March 2024 we will be offering a variety of digital services so people are able to access more health and care closer to home. This has the potential to significantly reduce the number of physical appointments in hospitals by anything up to 70%.

We also have a strong foundation of community and primary care in Surrey Heartlands and expect these services, often referred to as "out-of-hospital care" or "integrated care", to improve further over the next five years. This will include:

Community Rapid Response

Voluntary and community groups will share resources to help people with complex needs get the care they need to reduce pressure on our emergency services. We're developing digital apps to support our staff when they're working in the community and expect to pilot a number of these over the next year.

Transforming Community Support

People in Surrey with a severe mental illness are set to benefit from a ground-breaking new community mental health service designed to improve access to a wide range of specialist support. Extended appointments with mental health experts from the NHS, social care and specialist organisations, plus access to therapies, physical health checks and pharmacists, are just some of the expertise patients will be able to access via their local GP practice and in the community.

Rapid Response and Reablement (recovery) services

These services help prevent admission to hospital and when people are admitted, they are helped to get home sooner. There will be fully joined-up teams so we can help more people by reducing red-tape and freeing up more staff time to help patients.

Prevention and health inequalities

Helping people in Surrey lead healthy lives means not just addressing individual **lifestyle factors** – smoking, harmful drinking, excess weight – but also the **environment** in which they live. We want to make sure:

- People have a healthy weight and are active. We plan to increase use of outdoor space for exercise from our **current rate of 20.5% to a 'best in class' rate of 24.4%**.
- Smoking rates among adults employed in routine and manual occupations are reduced from **21.5% to a 'best in class' rate of 11% for this population.**
- Everyone lives in adequate housing. For people with a learning disability and/or autism, we want to move from our **current position of 66% of this population to 87% living in settled accommodation**.
- Diseases are prevented through vaccination and early diagnosis. We will **increase the coverage of MMR vaccinations from our current rate of 81.7% to 93.8%**.
- People are supported to live independently for as long as possible. **We aim to improve the effectiveness of short-term reablement services leading to nil or lower level ongoing support from 75.1% to 92.7%**.

We recognise that the majority of care in Surrey is provided by family and friends. We want to make sure carers are respected, recognised, valued and supported both in their caring role and as individuals. Our ambition is to **increase health checks for carers by 11% annually to achieve 3,050 by 2024 and to increase the number of flu vaccinations given to carers to 13,000 by 2024**.

Reducing pressure on emergency hospital services

Across Surrey Heartlands attendances at Emergency Departments (A&E) is increasing by approximately four per cent each year.

Our ambition is to ensure that 95% of patients are admitted, transferred or discharged within four hours. Each of our Integrated Care Partnerships is delivering plans to transform out-of-hospital services to see more people in the community and reduce A&E attendances so hospital staff can focus on those who are most ill.

We want to cut the number of people being taken unnecessarily to hospital by ambulance. We also want to make sure we are meeting the minimum standards for ambulance response times and will do this by recruiting more qualified paramedics and emergency care support workers*, reducing how long it takes ambulance crews to 'handover' patients to hospital staff, investing in our ambulance fleet and increasing clinical support in our emergency call centres.

We are developing plans to meet new national standards for Urgent Treatment Centres and each local partnership is also making plans to reduce the number of people stranded in hospital when they no longer need to be there, as this can have a detrimental effect on their recovery, rehabilitation and long-term health and well-being.

*Emergency Care Support Workers support qualified paramedics as part of the response team

A strong start in life for children and young people

By March 2024, we will work with children and families to make sure that every child has the best start in life, so they feel safe, confident and are able to fulfil their potential. The **first 1000 days**, roughly from pregnancy to two years old, is a critical phase in child development, and we are committed to making sure families across Surrey Heartlands have access to the care they need.

We will design our services with local women, ensuring they meet the needs of families, and provide personalised, safe care. We will develop plans based on the feedback we have already received and will continue to test our ideas with parents and families.

Improving quality

So far, all our local NHS trusts are rated **'good' or 'outstanding'**. 83% of adult social care services are rated 'good' or 'outstanding'. This includes a rating of 'good' or 'outstanding' for 71% of nursing homes, 86% of residential homes and 68% of domiciliary care. All GP Practices are rated 'good' or 'outstanding'. This means that **all our 24 Primary Care Networks are providing 'good' or 'outstanding' care overall.**

And we will continue to improve the quality of our care. The Surrey Heartlands Academy supports health and care practitioners to adopt, share and evaluate innovations, research and best practice.

Through our First 1,000 days work we aim to increase the proportion of children achieving a good level of development by the end of reception class from 53.5% to 61.3%. We continue to develop and transform our care for major health conditions, with a strong focus on bringing together physical and mental health services and support.

By 2024, we will have increased our one-year survival from cancer rates from 73.8% to 80%.

Having already **met the national target of 34% for CAMHS** (Children's and Adolescent Mental Health Services) access, we aim to achieve 38% by 2022/23. Our ambition is to reduce our average waiting time for CAMHS by at least a week each year. **We will increase the uptake of annual health checks for people with learning disabilities from 45% to 75%.**

We will speed up our work to reduce the average number of days people spend in adult acute mental health units to the national average of 32 days. This will support a reduction of out-of-area placements (people who are looked after in units that aren't in Surrey).

The Surrey Heartlands Academy is:

- A virtual network supporting health and care practitioners to adopt, share and evaluate innovation, research and best practice.
- Reducing unnecessary variation in people's care and standardising practice so that Surrey Heartlands citizens can expect the same levels of care and outcomes no matter where they live.
- Helping to create and establish a culture and environment for new ideas and then putting them into practice to benefit the Surrey Heartlands population.
- Creating training and development opportunities.
- The Academy has also developed a workforce panel and ambassador programme to support better working between different teams across the area and will introduce new technologies to further help the way information is shared.

National priorities

NHS England's Long Term Plan has set out the key issues for the health service to address in the coming years. Every local area needs to show how it plans to deliver improvements in these areas and for the people of Surrey Heartlands, we have set out the following plans:

Learning disabilities and autism

By March 2024, action will be taken to tackle the causes of illness and preventable deaths in people with a learning disability and for autistic people. We aim to work closer together to create a single team across Surrey County Council and the NHS.

We plan to increase the rate of people with learning disabilities who are in paid employment from 9.0% to 16.8%. NHS staff will receive information and training on supporting people with a learning disability and/or autism and it will be a contractual requirement that services are able to accommodate their needs.

Health checks

Receiving regular health checks is an important part of checking people's health and wellbeing. For people with learning disabilities we want to improve uptake of annual checks for people over 14 years to at least 75% of those who are eligible and to make sure they have a Health Action Plan as part of their annual review. We also intend to make sure we are providing appropriate services for people aged 14-18 as children transition through teenage-hood to adulthood. We also want to make sure that GP practices have a register of patients with autism and to introduce a specific health check for people with autism.

Autism diagnostic services

Children and young people with suspected autism wait too long before they are able to have a full assessment. Over the next three years, we will include autism assessments alongside other work we are doing within children and young people's mental health services to work out the most effective ways to reduce waiting times for specialist services. Our aim is to reduce this to 10 weeks from referral to treatment.

Cancer services

By 2024 we want people in Surrey Heartlands to live healthy and fulfilling lives to reduce their risk of cancer. If they are diagnosed with cancer, we want this to be as early as possible and to make sure they have prompt, high quality treatment, and feel fully supported so they have the best chance of survival and recovery, whilst maintaining a good quality of life.

Across Surrey Heartlands, we already have some positive cancer patient outcomes with 75.6% (2016) of patients surviving one year. **We aim to improve one year survival rates to 80%.** Through the National Cancer Patient Experience Survey (2018), patients are reporting positive experience of care with an average patient rating of 8.9 out of 10. However, there are still areas that need to be improved to make sure all patients can expect the same likely outcomes.

The impact of alcohol and obesity on cancer rates is an issue in Surrey and this will be an area of particular focus, alongside smoking cessation programmes for the most deprived areas, as smoking rates are much higher amongst these communities.

Screening and prevention

We want to increase cervical cancer screening rates from 72% in (2017/18) to 77.7% over the next 10 years and increase bowel cancer screening from 58% (2017/18) to 65% by 2024 and will continue to improve screening uptake overall, including breast cancer.

We will also work with the local community, providers and Public Health England to address health inequalities in screening and ensure staff have the right skills to support healthy living.

Earlier and faster diagnosis

We will continue to drive for earlier and faster diagnosis of cancer to ensure better outcomes for patients and improve survival rates, including achievement of the new 28 Day Faster Diagnosis Standard to make sure all patients find out whether they have cancer or not as quickly as possible.

Treatment

We will continue to improve our treatments and services for people with cancer, particularly specialist radiotherapy services and cancer care for children and young people. We want to continue providing the existing high-quality, specialist complex cancer surgery within Surrey Heartlands to limit disruptive travel and ensure that care is provided closer to home wherever possible.

Enhanced supportive care

This is a new national programme to support the physical and psychological needs of patients with cancer who are receiving treatment at the Royal Surrey County Hospital. A dedicated team will include specialist consultants, doctors and nurses, with outpatient consultations offered face-to-face at St Luke's Cancer Centre, or via telephone or video consultation. We will make the most of digital technology to promote accessibility to the new service, and help clinicians to monitor patient symptoms remotely.

Cancer workforce

We will continue to support, build and develop our cancer workforce so we can provide all patients, including those with secondary cancers, with the right expertise and support. We will address staff shortages to ensure all patients have access to a Clinical Nurse Specialist or other support worker and will support nurse-led services.

Cardiovascular disease

Cardiovascular disease is a leading cause of death in the UK responsible for one in four deaths in England. In Surrey approximately 20% of deaths in 2017 were caused by either heart disease or stroke. The NHS long term plan states that cardiovascular disease "is the biggest single area where the NHS can save lives over the next 10 years" .

Across Surrey Heartlands we have created a dedicated programme which brings together the prevention, detection and treatment of cardiovascular disease, including work to increase detection of high blood pressure, atrial fibrillation (an irregular heart rhythm), cardiac high risk conditions and high cholesterol. This includes:

- Blood pressure checks in partnership with high street pharmacists, voluntary groups and local NHS and County Council staff across Surrey Heartlands. Since launching the BP+ scheme on 1st April 2019 over 2000 checks have been delivered identifying hundreds of patients with high blood pressure.
- We are working to increase uptake to our cardiac rehabilitation programmes, using technology and group clinic approaches.
- We are linking people to preventive programmes to reduce health risks such as alcohol, obesity, smoking and lifestyle management. These programmes are forming new partnerships across local industry, communities and the voluntary sector.
- We are also working with South East Coast Ambulance Service and the British Heart Foundation to develop a national defibrillator database. This means ambulance call handlers will be able to direct people in Surrey to the nearest defibrillator.

Stroke care

New stroke delivery networks, bringing together ambulance services and other care providers, will help improve stroke care including making sure that our stroke units meet all the national standards, including access to specialist stroke beds when someone arrives in A&E. The good access to thrombectomy services (removal of blood clots) at St George's Hospital will continue, with clear processes in place for rapid treatment.

We also want to see a reductions in strokes and improved outcomes for those who do have a stroke. We will make sure that patients, carers and voluntary sector organisations are fully involved in shaping future services, building on what people have already told us.

Diabetes

By March 2024 people with diabetes can expect the same levels of care across Surrey Heartlands including care from GPs.

Everyone at risk of developing type 2 diabetes will be identified and offered a place on the National Diabetes Prevention Programme. People with diabetes will be offered support to look after themselves through various education programmes. Digital services will be improved, we will prescribe flash glucose monitors that do not require finger pricks, and **by 2021 all pregnant women with type 1 diabetes will be offered continuous glucose monitoring.**

We will work with champions from Diabetes UK so people at risk of developing diabetes are screened, identified and engaged with early. We also plan to design better ways for GPs to identify and support people with diabetes, to make sure patients have access to multidisciplinary foot care teams and offer people with type 2 diabetes the option to self-refer to face-to-face and digital education programmes.

Respiratory (lung) disease

We want patients with respiratory disease to be diagnosed earlier, supported by self-management and rehabilitation. We now have a consultant-led community service to help patients with chronic obstructive pulmonary disease, asthma, bronchiectasis and interstitial lung disease (which causes scarring on the lungs making it harder to breathe). This service will improve quality of life, helping to prevent unnecessary hospital admissions or re-admissions and support people once they have been discharged from hospital.

Pharmacists working in primary care networks are able to help patients with medication reviews – discussing and looking at all the medicines someone might be taking - including teaching people how to use inhalers correctly.

Adult mental health services

Our vision is a future where people's mental health is part of their story but does not completely define them, building on the priorities we've set out in our 10-year health and wellbeing strategy.

Surrey Heartlands is one of 12 areas which has been awarded national funding to develop a community mental health service for adults and older people with serious mental illness. This will help us identify people with mental illness at an earlier stage and help to make it easier to access services, with better support for young adults (18 to 25s). People will be treated nearer to home by local services within their communities and supported through social prescribing and our Recovery College which helps people find local health and lifestyle opportunities. We expect more people with serious mental illness to have full annual health checks, and more people will have support to find and stay in work.

We want more than 26,000 people to get help through psychological therapies by 2023/24; and our new community mental health perinatal service means women have access to specialist support during or after pregnancy.

Families and staff will be able to access suicide bereavement support more easily across Surrey Heartlands.

We will increase our Crisis Response Home Treatment hours at evenings and weekends, expand our successful Surrey High Intensity Partnership Programme (with Surrey Police), build on the number of peer support workers we have and create a care network with our partners.

Housing is also a key focus area and will benefit from a dedicated mental health discharge team from social care coming into place at the end of 2019.

Shorter waits for planned care

We know that some services are particularly vulnerable to issues such as waiting times and we want to make sure we keep these as short as possible. Working together with the Frimley system, we will create a multi-professional team from each key specialty to focus on areas where waiting times have been a particular problem to ensure all patients can access high quality services in a timely manner.

Across Surrey Heartlands we continue to work on meeting national waiting time targets and have set up a dedicated transformation programme to support this with specific projects to:

- Reduce waiting lists across the board
- Make sure **no patient waits more than 52-weeks from referral** from their GP to the start of their treatment (the national target is for at least 92% of patients to wait no more than 18 weeks)
- Make sure any patient who is waiting more than 26 weeks is offered treatment by a different provider, a new requirement set out in the NHS Long-term Plan
- Make sure patients with musculoskeletal (bones and joints) problems have direct access to practitioners such as physiotherapists without the need to see a GP first.

Supporting our workforce

Staff are our most important resource. We recognise that we must develop and support our workforce in order to deliver our ambitions on behalf of local people.

Our vision is to have the right team, with the right tools and skills, providing care in the right place and at the right time, to meet the needs of local people. Living in Surrey has many benefits, but a relatively high cost of living and proximity to London, with its higher salaries, presents challenges for recruiting and retaining staff. We want to make Surrey Heartlands recognised as the 'Best Place to Work' and we will be developing a new Equality, Diversity and Inclusion Strategy in early 2020.

Through the 'Surrey 500', Surrey Heartlands' first large-scale leadership programme, we are offering the opportunity for individuals to learn with colleagues from across our health and care system.

Digitally enabled care

By March 2024, we will have access to a wide range of digital tools and services, with locally-shared health and care records supporting high-quality care. We will make sure our staff have the right digital skills, with central investment in the latest technologies to support new services. Citizens will have digital care plans and personal health records and be involved in the design of digital services to ensure they are safe, ethical and effective.

The greater use of digital technology will be particularly felt in improvements to outpatient services. Our population will be able to access health and care support in more convenient ways and closer to home without having to travel to unnecessary outpatient appointments. Instead, where appropriate, people will be connected with trained professionals, virtual clinicians and care providers, and digital services that can direct people to the best options for their needs.

This will not only be better for local people and patients, but will help reduce our environmental impact and free up more time to support those with greatest need.

Balancing the books

We are committed to addressing the financial challenges all NHS organisations are facing through the transformation of services outlined in our plans and we aim to close the financial gap in our system by March 2022.

This requires a big change in the way we work.

Our out-patient and digital transformation work, along with moves to more personalised care and bringing together health and social care will be a big part of this. We will also work with local councils to share buildings and create "one public estate" for the people of Surrey and will continue developing further efficiencies to support this plan, including making the most of the opportunities presented by our devolution deal.

Continuing to work with our communities

This plan is not the end of the story. We will continue to work in partnership with citizens and partners across our community as we refine and implement these plans over the next five years, so we can continue improving and developing health and care services for local people.

For more information on Surrey Heartlands please contact us at:

www.surreyheartlands.uk – where you can also sign up to our regular newsletter

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