Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY
COUNTY COUNCIL

NHS

Surrey Heartlands Health and Care Partnership

Our plan for 2021/22

This plan summarises how we are improving care for people living in Surrey Heartlands and how we will meet national NHS priorities.

Contents

Introduction from Dr Claire Fuller

Our plans for the next six months are set against a backdrop of the challenge to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the Covid-19 pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.

As a health and care system we have three continuing priorities; the wellbeing of our staff, particularly in light of the events of the past year; the recovery and restoration of services; and the continuation of our successful vaccination programme and ongoing care to those still suffering from Covid-19.

We know that the pandemic has exacerbated health inequalities across many communities; in particular we know that our Black, Asian and Ethnic Minority (BAME) populations have been hard-hit. We want to build on the learning of the past year to strengthen our relationships with these communities and address health inequalities in a new and real way. Another direct result of the pandemic has been the exponential increase in demand for mental health services and we have to find ways to address this and help those who are struggling. And we also want to ensure a clear focus on those with learning disabilities and autism, particularly delivery of the Learning Disabilities Mortality Reviews (known as LeDeR) to improve life expectancy.

Transforming how we provide health and care, working closely with citizens, our communities, staff and wider partners, will be critical to helping us achieve these plans over the next six months and beyond.

Claire

Senior Responsible Officer for
Surrey Heartlands Integrated Care System

NHS national priorities for 2021/22

- **Supporting staff health and wellbeing** and taking action on recruitment and retention
- **Delivery the NHS Covid-19 vaccination programme** and continuing to meet the needs of patients with Covid-19
- **Transforming how we deliver services**, accelerating the restoration of planned care, including cancer, and managing the increasing demand on mental health services
- **Expanding primary care capacity** to improve access, local health outcomes and addressing health inequalities
- **Transforming community and urgent and emergency care** to prevent inappropriate attendance at emergency departments
- **Working collaboratively across health and care systems** to deliver these priorities

1. Looking after our people

Collectively, Surrey Heartlands partners make up the largest employer in Surrey and we take pride in providing first-class careers. Making sure we have the right staff, with the right skills, is key to providing the best possible care to our population including our volunteer workforce and the third sector. As an aspiring **Anchor Network** we have committed to work together to make lasting change and provide great employment opportunities that impact positively on our population.

The past year and a half has been an extraordinary time for our workforce, with many staff exhausted and even traumatised by the impact of the pandemic. The coming year is critical as we look to restore services at the same time as supporting staff to recover and attracting the talent we need. Digital transformation has rapidly changed how staff work and how patients access services. This year will also see further change as we transition to a becoming a statutory Integrated Care System (ICS) in line with the Government White Paper, which will have an impact on many teams across our system.

Some of the key actions for the next six months include:

Prioritising health and wellbeing

We support the health and wellbeing of our staff through our well-established Staff Resilience Hub – an online resource for staff and volunteers providing a variety of psychological support – new training packages (Trauma Risk Management; Sustaining Resilience at Work), and further development of our Mental First Aid training. All organisations have health and wellbeing support packages in place for staff – including initiatives such as wellbeing cabins, support to encourage staff to take breaks and Wellbeing Guardians – and will continue to monitor both uptake and impact.

Belonging in the NHS and addressing inequalities

We know that Covid-19 has had a disproportionate impact on our BAME communities and our workforce in particular and have set up a robust process to address risks and protect staff, particularly those in front-line roles. We are prioritising our equality, diversity and inclusion work focusing on listening and engaging with staff across all groups; taking action on employment practices and recruitment; and strengthening the quality of data so we can take more effective action.

We have a strong **BAME Alliance** challenging ourselves to take proactive action against racial bias, inequalities and discrimination, and a **Turning the Tide Oversight Board** which considers racial and other inequalities, making sure we reach out to all our communities - a key strand within our Covid-19 vaccination programme. Over the next six months we will be developing a system **Equality, Diversity and Inclusion** Strategy and setting up a **Disability and LGBTQ+ Alliance** and looking more closely at ethnic and gender pay gaps.

Embedding new ways of working

As a system we want to develop our workforce and transform how we work to continue to offer innovative and first-class care to our population. We are supporting staff to work more flexibly, across different wards and specialties, and from home where appropriate. We have signed a 'sharing of staff' **Memorandum of Understanding** so staff can be easily deployed where they are needed, for example to support our vaccination programme, and are hoping to set up digital staff passports so staff can move across organisations more easily.

As we change the way we work, training is critical; for example, supporting staff with using new digital tools, upskilling to close vacancy gaps and creating new roles to support new ways of working across health and social care. We are creating more multi-professional teams in key areas such as end of life care, hospital discharge and primary care network development and are continuing to recruit new roles – clinical pharmacists, social prescribing and others – to support new ways of working across our primary care networks.

Growing for the future

As an aspiring Anchor Network, we recognise we can act as an anchor institution to support our local communities and positively impact social, economic and environmental areas. Looking ahead, we want to build on the significant public support experienced during the pandemic and associated interest in health and social care careers. We also want to tap into new and under-utilised markets, such as young carers and less engaged groups as well as continuing well-established international recruitment plans.

Recognising the challenge of our proximity to London with higher salaries and increased competition for jobs, we have developed a Surrey Heartlands awareness and recruitment campaign and are embedding new roles and development opportunities to aid retention. We are also looking to develop a clear Surrey Heartlands employer brand. Other recruitment initiatives include an apprenticeship forum – including a Registered Nurse Degree Apprenticeship – and continued influencing for new undergraduate courses to help create the future workforce we need. We will continue to grow our talent, developing career pathways that cross organisational boundaries, support our primary care colleagues to achieve portfolio careers, particularly amongst younger GPs, to keep them working in our system for many years to come.

2. Continuing our response to Covid-19

As we emerge from the second wave of the pandemic, we continue to look after patients suffering from Covid-19, including those with long-Covid, to protect our population through our vaccination and testing programmes and make sure we are prepared for any future waves.

Delivering the Covid-19 vaccination programme

We are making good progress with vaccinating our population through 16 local GP-led vaccination sites, our larger site at Sandown Park racecourse (formerly at Epsom Downs), 11 community pharmacy sites, three hospital hubs and proactive outreach and roving services. We will continue to drive the programme to offer first and second doses to all adults in line with JCVI recommendations, with a particular focus on those communities where there is more vaccine hesitancy, using behavioural insights, targeted communications and outreach, and working with trusted community leaders.

We are now planning 'Phase 3' of the programme, which takes into account the introduction of new vaccines (such as Moderna), the sustainability of our workforce alongside potential autumn boosters and the possibility of vaccinating the under 18s.

Covid-19 testing programmes

The Surrey Testing Cell is a joint team working across Surrey Heartlands health colleagues and Surrey County Council providing a range of testing programmes including antibody testing, asymptomatic community testing, PCR testing for outbreaks in places such as care homes, mobile testing units (which have supported local outbreaks) and surge testing which was used earlier this year to identify potential cases of the South African variant (now known as Beta variant). As we move forward our testing cell will continue to operate and flex these local testing services according to local need/outbreaks and to reflect latest Government guidance.

PPE

We will continue to support local providers to ensure they have access to all the PPE (personal protective equipment) they need, either through the national online portal or where needed via our Local Resilience Forum. We undertake daily reviews of stock levels across local providers and have a mutual aid process in place across the South East.

Continuing to look after patients with Covid-19

We now have significant additional capacity to look after those suffering from Covid-19 including a range of services that patients can access in their own homes via digital technology. This includes home oximetry which allows patients' oxygen levels to be monitored remotely, the introduction of virtual wards and remote monitoring in care homes. We have also made it easier for patients to self-refer and access other support such as social prescribers and care coordinators online. Moving forward we plan to build on this digital infrastructure to expand services and make it easier for people to get the support they need, when they need it.

We have also put in place a clear long-Covid pathway within each of our 'Place' systems, to support the ongoing needs of patients, including psychological and medical needs.

Preparing for future waves/outbreaks

We continue to work with colleagues in public health and NHS England/Improvement to proactively model and prepare for any further outbreaks of Covid-19 and any impact on services and our workforce, taking into account mitigating factors such as the impact of the vaccination programme.

3. Recovering and transforming services

As we focus on recovering services, we are in a strong position compared to many other systems, having maintained at least 50% of most services at pre-Covid levels throughout the recent second wave between December 2020 and March 2021. Our aim now is to recover our planned activity levels quickly and then maintain or increase these over the next six months. Planned activity refers to scheduled operations/procedures, outpatient appointments and diagnostic testing. At the same time, we need to reduce the increase in waiting lists, maintaining these at consistent levels whilst significantly reducing the number of people experiencing very long waits.

As a system, Surrey Heartlands has successfully bid to be part of the national elective accelerator programme with additional funding and help to support this work.

In planning our recovery, we will be taking advantage of opportunities to transform services improving the patient experience and making them more efficient, including digital innovation and learning from best practice - recognising that some patients may be nervous to attend appointments (trying to mitigate against that anxiety) and that some routine surgery is being postponed to make space for urgent or cancer work.

Our key areas of focus include:

Increasing capacity

Creating elective hubs and additional theatre capacity including more use of the independent sector; extending daytime and weekend operating/diagnostic times; improving hospital discharge processes; more use of **patient-initiated follow-up** (where appointments are generated in response to patient need rather than generated automatically); expanding the use of **Advice and Guidance and Consultant Connect** (giving GPs swift access to specialist advice to prevent unnecessary referrals).

Improving productivity and reducing waste

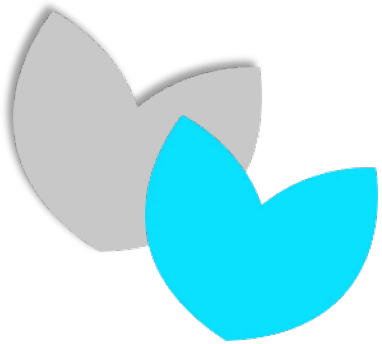
Using **Get it Right First Time (GIRFT)** benchmarking to identify specialties/pathways where further transformation/improvement will improve productivity, for example improvements have already been made to the colorectal pathway, including theatre productivity and reduction in length of stay across the system.

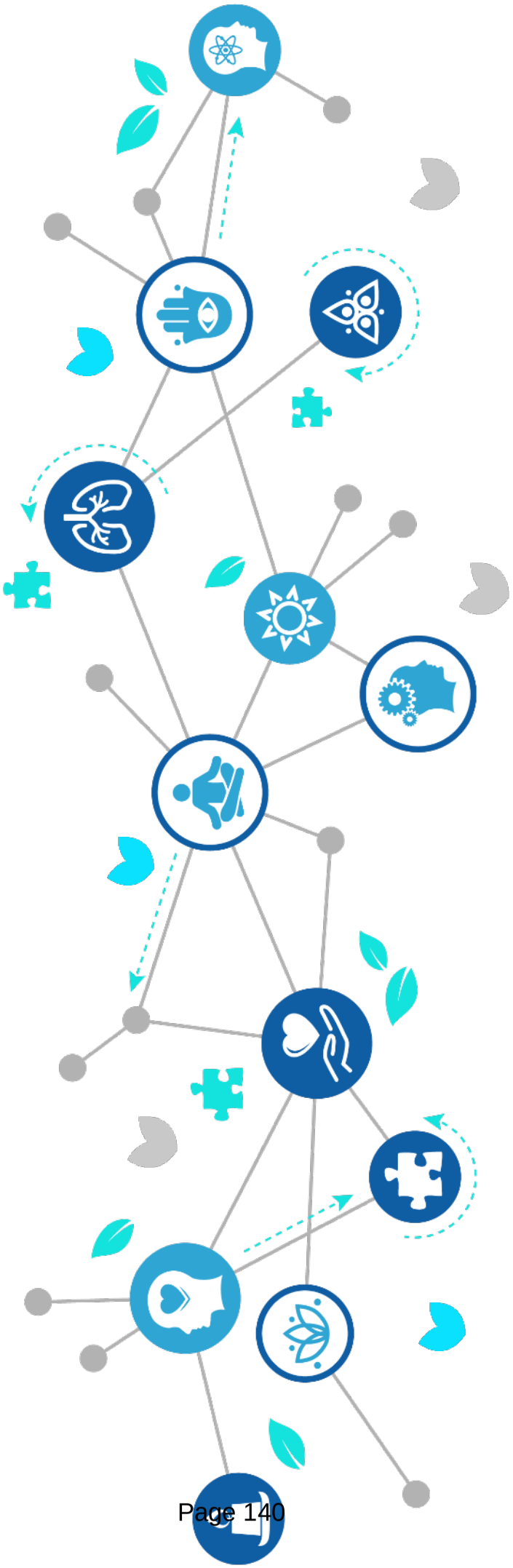
Transforming pathways

Managing demand and waiting lists through our low intervention musculoskeletal pathway and more use of the **First Contact Practitioner** programme; taking advantage of new digital innovations in ophthalmology, cardiovascular disease and dermatology, streamlining care including support for self-management; improving identification and surveillance of cardiovascular disease patients (strongly associated with health inequalities) engaging local communities in targeted educational conversations; building on digital transformation pilots in dermatology aimed at supporting faster diagnosis, treatment and triage to reduce waiting times and high referral rates.

Waiting list management

Introducing a number of specialty-level shared **patient tracking lists** across our providers; using our detailed surveillance report (developed during the pandemic) to oversee the numbers and waiting times for each specialty; and piloting the use of patient texting (via primary care) to help manage waiting lists.





4. Our plans for cancer services

We have worked closely with both the Surrey and Sussex Cancer Alliance (SSCA) and the regional cancer NHS England/Improvement team to minimise the impact from the pandemic on cancer services. Significantly higher levels of activity have been maintained during this second wave (compared to the first), ensuring that patients on a cancer pathway have had good access to diagnostic tests and treatments. SSCA was pivotal in establishing robust mutual aid (locally and regionally), enabling organisations to work together to deliver the best care to their sickest patients. Furthermore, much of the activity that was paused/reduced during the first wave has been maintained this time, including the restoration of screening services.

Key activity over the coming months will be to:

Manage referrals and capacity

Implement the **Ardens Pro** GP referral support system (funded by the SSCA) to improve the standard of cancer referrals and reduce unwarranted variation; continue pilots such as 'straight to test' CT lung pathway; working with SSCA and community partners to understand barriers to accessing cancer services particularly with seldom heard communities; extending surgery, chemotherapy, radiotherapy to 6-7 days/week where possible; maintaining a virtual hub (by the SSCA) for patients where there is no capacity locally; and build on new practices established during the pandemic, such as the 'chemo bus'.

Quality and safety

Carry out clinical harm reviews for anyone waiting over 104 days for treatment in line with NHS England guidance.

Strengthen communication and identification of patients

Developing targeted campaigns to raise awareness of specific cancers (including ovarian, lung, prostate and pancreatic) alongside a wider cancer awareness strategy; use agreed criteria to search for high-risk patients who haven't come forward, for example smokers with a history of haemoptysis, and those with chronic obstructive pulmonary disease.

Leadership for screening initiatives at Place/ICP level

To make the most of screening initiatives locally.

5. Mental health services

As a result of the pandemic, there has been an exponential rise in demand for mental health services both for adults and for children and young people. Factors such as employment and financial insecurities and the isolation and disruptions caused by prolonged lockdowns have impacted the emotional wellbeing of many people, including many not previously known to mental health services. There has also been a significant increase in the number of children with eating disorders.

Across the system, we have now set up an independently chaired Mental Health Partnership Board, recognising the need for a new approach to improving and expanding mental health services with membership from a broad number of partners including schools and businesses, a real step-change in approach.

Our plans to expand and improve mental health services over the next few months include:

Adult mental health services

- Improving and expanding crisis services, including increasing bed capacity and support.
- Expanding our GP Integrated Mental Health Services – which provides specialist mental health access and support in primary care settings.
- Transforming our community mental health teams.
- Better dementia diagnosis and support post a diagnosis.
- Expanding our perinatal mental health service.
- Working to reduce the number of out-of-area placements (patients who have to be looked after outside Surrey) which rose during the pandemic.
- Taking advantage of digital innovation to improve services.
- Recruitment of a BAME outreach officer to improve support to our BAME communities.
- Implementing our Mental Health Partnership Board improvement plans.

Services for children and young people

- Mobilisation of the new **Emotional Wellbeing Mental Health** contract for children and young people (being undertaken by an Alliance of organisations) which includes an additional £6m investment and a focus on early intervention, and to reduce service backlogs.
- Supporting schools in line with the new contract mobilisation timescale.
- Establishing a Tier 4 **Provider Collaborative** to provide a number of high acuity eating disorder beds within Surrey.
- Focused action on suicide prevention and reduction of self-harm.

6. Services for people with a learning disability and/or autism

Our plans include:

- Making progress on the delivery of annual health checks for people with a learning disability and/or autism and improving the accuracy of GP Learning Disability Registers.
- Reducing reliance on inpatient care for both adults and children with a learning disability, focusing on community support and better admission avoidance, and including the completion of purpose-built housing.
- Implement 100% of the actions coming out of LeDeR (Learning Disability Mortality Reviews) within 6 months of notification, including recruitment of new staff to undertake this work, including engagement with local *Valuing People* groups to develop the ongoing involvement of people with lived experience in the programme.

7. Improving maternity care

Across Surrey Heartlands our maternity services – including providers, commissioners and local maternity voices – work as one **Local Maternity and Neonatal System**. Our plans over the next six months are focused on delivering improvements in maternity care as part of our **First 1000 days** programme, as well as responding to the recommendations of the Ockenden Review (an independent maternity review into cases of serious concern at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020).

These include:

- Recovering all aspects of maternity services following the pandemic – making sure we are offering all services within the maternity pathway with choice of birth location; removing any restrictions to support for women throughout the maternity journey; and making sure that the specific needs of Black, Asian and Minority Ethnic and vulnerable women are identified and met.
- Delivering the priorities for 2021/22 set out in our **Maternity Transformation Plan** – this includes the **Saving Babies Lives** care bundle; personalised care planning; reduction in the number of women smoking during pregnancy; continuity of carer delivery and development of community maternity hubs; local neonatal improvement plans; provision of full digital maternity records at all maternity units; further development of the maternity advice line; and workforce training, safety and support, particularly in line with the Ockenden Review.
- Review of local maternity and neonatal governance arrangements.

8. Improving access to primary care and addressing local health inequalities

Primary care is currently experiencing a substantial rise in activity, with a large proportion of this increase driven via online access. Over the last 12 months we have provided over 6 million appointments, an increase of 28% on the previous year, with around 2.7 million of these provided face-to-face.

Our key activity over the next few months includes:

Access to primary care services

Over the coming months we will be listening to our patients via real-time data and feedback to improve overall experience and manage demand more appropriately to reduce pressure and ensure patients get the most appropriate care when they need it. We will also be building on our OPEL framework for general practice which helps identify rising pressures (in a similar way to other parts of the system) helping us to direct resource where it is most needed; a unique development for Surrey Heartlands this framework has now been adopted across the South East.

Developing our eHub model

This is a new way of delivering services within general practice using data and digital technology to triage and proactively provide the most appropriate care for patients, such as urgent face-to-face care, remote monitoring or coordination with other services and partners across the local community.

Developing 'Thriving Community Networks'

Using our Primary Care Networks as local geographical footprints, we are supporting the development of '**Thriving Community Networks**'. This is about working in partnership with local providers, citizens and the third sector to influence and design local services, using population health management data* to meet the specific needs of these communities, and making sure our Patient Participation Groups are supported to grow into strong, effective parts of these wider community networks.

Our primary care networks are at the forefront to deliver a range of population-based, personalised and preventative care to improve health outcomes and address health inequalities, marking a step-change in how we deliver care at this very local level.

* population health management allows us to use data at a local (primary care network) level to help us meet the specific needs of local communities, helping us improve health outcomes and reduce health inequalities.

Further improving uptake in the NHS diabetes prevention programme

Over the past few years, we have developed a leading transformation programme to improve diabetes outcomes including supporting better diabetes reviews, a wide education programme, producing guidance for care homes and a review of multi-disciplinary footcare services for people with diabetes to reduce amputation rates and will continue this work to further improve outcomes including implementation of a new Diabetes Strategy.

Progressing prevention of cardiovascular disease

Cardiovascular disease is one of the conditions most strongly associated with health inequalities, with those living in more deprived areas almost four times more likely to die prematurely due to cardiovascular disease. The Covid-19 pandemic has negatively affected prevention; risk factors are often picked up opportunistically during face-to-face appointments; lockdown has also negatively affected healthy behaviours. We are now working on a whole system strategy to promote uptake of healthy behaviours reduce unwarranted variation and improve detection and management of risk factors such as atrial fibrillation, hypertension, high cholesterol and type 2 diabetes.

Stroke services

The Frimley/Surrey Heartlands integrated stroke network aims to support the development of high quality and equitable stroke services to achieve best outcomes and experiences for our populations, supporting improved service standards and reducing areas of unwarranted variation. This will include development of a prevention strategy, improving access to thrombectomy services, reducing health inequalities and improving community stroke rehabilitation.

Respiratory disease

This affects one in five people in England and is the third biggest cause of death. Our ambitions are to target improved treatment and support for those with respiratory disease to transform outcomes for our population. Encouraging people to stop smoking is a key preventative element and we are starting a three-year programme to deliver '**Tobacco dependence treatment services**' in line with the Long-term Plan commitments. We also want to create community diagnostic hubs to improve access to accurate diagnostic services (e.g., lung CT scanning, lung function testing and spirometry), with our Covid@home and virtual ward models continuing to support early diagnosis and management of acute Covid patients suitable for this type of care in the community. We will also improve services for those with chronic obstructive pulmonary disease and pulmonary rehabilitation, particularly at Place level.

Using personalised care plans

We are working to support greater use of personalised care plans throughout health and care services, making sure our staff are equipped to support individuals develop their own wellbeing plans, increasing the number of social prescribers and working closely with all partners, particularly district and borough teams. We are also a test site for **Green space prescribing** focusing particularly on mental health, people with long-term conditions and those with learning disabilities.

Dental services

Traditionally NHS England has held responsibility for commissioning dental services. As we move towards becoming a statutory ICS we want to take greater responsibility for the oral health of our population particularly given the impact of the pandemic on dental services, developing the right commissioning plans and looking specifically at dental checks for children and young people with a learning disability and/or autism.

9. Transforming community, urgent and emergency services

During the pandemic, we have done a lot of work to reduce the number of people staying in hospital for a long time (also knowing that long stays can reduce independence and be more harmful to patients in the long run) and to ensure those who are medically fit are discharged as soon as possible.

We want to build on this work and our plans include:

Reducing the average length of stay

Looking particularly at stays of more than 14 and 21 days – using our single integrated discharge to assess pathway across health and social care; making best use of expanded capacity outside hospital (for example expanded care home beds and domiciliary care); continuing our focus on preventative services and admission avoidance.

Crisis community health response

Accelerating the rollout of the 2-hour crisis community health response at home to provide consistent cover (8am-8pm, seven days a week) by April 2022 – which helps to prevent admission to hospital.

Urgent and emergency services

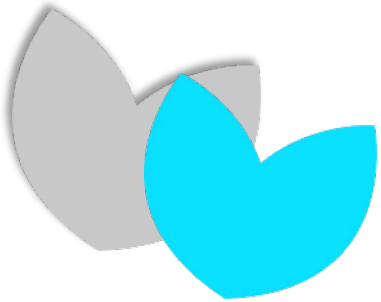
In line with national policy, we want to accelerate the use of NHS 111 as the main route for accessing urgent care, including the use of booked appointments in A&E. We will do this by:

- Continuing to promote NHS 111 as the primary route to urgent care services
- Aiming to provide a booked time slot in A&E for 70% of patients referred by NHS 111
- Providing direct referral from NHS 111 to other hospital services (including same day emergency care and specialty hot clinics) and referral pathways from NHS 111 to urgent community and mental health services
- Having a consistent, expanded model of same day emergency care provision across our system, to avoid unnecessary hospital admissions
- Using an **Emergency Care Data Set** within all services to monitor pressures.

10. Reducing health inequalities

We know that the Covid-19 pandemic has exacerbated health inequalities and we need to reduce these and close the gap wherever we can. Our recovery work continues to be planned in a way that inclusively supports those in greatest need by working with communities and our partners through our **Equality and Health Inequalities Workstream**. To support this, we have gathered a range of insight and intelligence including our **Community Impact Assessment** (which measured the impact of the first Covid-19 wave on communities), development of a health inequalities dashboard to monitor key priorities, and community-based surveys led by the third sector.

Meaningful community engagement is key, and we are building on this as we develop our local relationships. For example, through our targeted response to the vaccination programme which includes development of a short film to overcome vaccine hesitancy with the Gypsy, Roma, Traveller communities; working with local trusted leaders to increase confidence for example with our BAME communities; and developing resources for our local Covid champions to take out into communities.



Going forward, key priorities include:

Restoring NHS services with a focus on inclusivity

For example, ensuring equity of access for key services such as cancer waiting times; improving early access to diagnosis; monitoring the uptake of virtual consultations; improving access to mental health services; and focusing on community-based interventions.

Reducing digital exclusion

Working with local community and voluntary sector organisations to help people get online (for example the **Tech to Connect** project); development of a large-scale qualitative research project to fully understand different characteristics of digital exclusion so we can mitigate against them, including bespoke teaching and training packages, 'Tech' points in local libraries, and using trained volunteers and digital navigators to enhance people's digital literacy skills.

Improving insight and analytics

To help us target our response. Our health inequalities dashboard includes 51 indicators related to health inequalities; we also aim to improve the quality and reach of our data including protected characteristics.

Developing preventative programmes

To proactively engage those at greatest risk of poor health outcomes, including those most at risk from Covid-19; developing care plans for those who are particularly vulnerable, such as those with learning disabilities and severe mental illness; enhancing cardiovascular prevention; and continuing to roll-out workplace health checks prioritising BAME staff.

Strengthening leadership and accountability

Including the work of our Equalities and Health Inequalities Board.

11. Working collaboratively across our health and care system

As an ICS we have a duty to work collaboratively to deliver our priorities, making sure these reflect local circumstances and health inequalities and that we have the right infrastructure and approach in place to do this.

Since publication of the Government White Paper earlier this year, we are now preparing to become a statutory ICS from April 2022. This work will be supported by a robust development and engagement plan with our workforce, partners and wider stakeholders over the coming months as we prepare for this important transition. The new organisation will take on many of the former responsibilities of CCGs, including citizen and patient involvement and engagement, and will work collaboratively across the health and care system to deliver care and tackle the wider determinants of health in new and more joined up ways to improve patient outcomes.

A commitment to ongoing engagement

As we move forward, both as a system and across our local Place-based partnerships, engaging with and involving citizens and local communities needs to be at the heart of our planning. In delivering the priorities outlined in this plan and as we continue to transform services, we will work closely with patients, citizens, staff and stakeholders to make sure we continue to reflect the needs of local people and our wider workforce.

To find out more information on this plan and on our work towards becoming a statutory ICS, please see our website at:
www.surreyheartlands.uk

June 2021

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