Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

Surrey Heartlands

Integrated Care System

An introduction and overview

Helping people in Surrey live better and healthier lives

What is **Surrey Heartlands?**

At its simplest level Surrey Heartlands is a partnership of health and care organisations working together to improve local services and support people to live healthier lives.

Originally one of the 44 Sustainability and Transformation Partnerships to bring health and care organisations together across local areas, Surrey Heartlands has evolved into a more mature partnership and is now one of 17 **Integrated Care Systems** across England.

Integrated care systems are well developed partnerships where health organisations, the local authorities and others take a collective responsibility for improving the health of the local population, managing resources (including money) and delivering high quality health and social care. See more at **www.england.uk/integratedcare/integrated-care-systems/**

Partners:

- Ashford & St Peter's Hospitals NHS Foundation Trust
- CSH Surrey
- Epsom & St Helier Hospitals NHS Trust
- Guildford & Waverley NHS Clinical Commissioning Group
- North West Surrey NHS Clinical Commissioning Group
- Royal Surrey County Hospital NHS Foundation Trust
- South East Coast Ambulance NHS Foundation Trust
- Surrey & Borders Partnership NHS Foundation Trust
- Surrey County Council
- Surrey Downs NHS Clinical Commissioning Group
- Surrey Heartlands GPs

Including a close working relationship with Healthwatch Surrey as well as the local voluntary, community and faith sector. We are also starting to work more closely with partners in East Surrey to look at how we can share and join up ways of working across the county.

The Surrey Heartlands' story

Helping people in Surrey live better and healthier lives

We all want people in Surrey to live in good health for as long as possible throughout their lives. And that they get the right help, when and where they need it.

Surrey is already one of the healthiest places to live in England, with better cancer survival rates and people less likely to have a stroke or heart attack than many other areas. Our services also perform well with the majority of GP practices and hospitals rated good or outstanding.

However, there are big differences between what most of us experience and what some of us can expect, with a 12 year gap in life expectancy depending on where you live. We know that if a child starts school with a health inequality – such as from obesity or living with poor air quality – it's difficult to make up that gap, and they're more likely to have poor physical and mental health as they get older. And because most people in Surrey are living longer that also means more people living with ill health and conditions such as dementia, with social isolation and loneliness increasing.

In Surrey Heartlands we are focussing on the first thousand days of every child's life, so we can make a difference to our future generations, and on organising ourselves differently so people can continue to live well at every stage of their lives.

Take our example family...

83 year old Mary has recently been admitted to hospital following a fall. She lives alone, has mild dementia and has been feeling quite isolated. She also suffers from Type II diabetes. The longer Mary stays in hospital, the more likely she will be to deteriorate. But to get home she needs a package of care that includes nursing, help with her diabetes and support to enable her look after herself and remain independent.

As a partnership, we are supporting teams of doctors, nurses, care workers and other professionals to work together so people like Mary get home from hospital when they no longer

need to be there, with one person coordinating everything she and her family need. Shared medical records mean staff can see Mary's history quickly so she doesn't have to tell her story over and over again. And with the right links, through our partnerships with councils and voluntary groups, the team can put Mary in touch with social groups for company, helping her to live independently at home for longer.

Mary's son John, in his mid-50s, works long hours in London with little time to think about his health. Through a new community detection programme, using a simple device to assess his pulse, he was recently diagnosed with atrial fibrillation, an irregular heart rhythm and a major cause of stroke.

Now John is being treated with a drug that prevents his blood from clotting as quickly or as effectively as normal, which reduces his risk of having a stroke. Other digital initiatives, such as online GP appointments, also mean it will be easier for him to talk to a doctor with his busy lifestyle.

Mary's granddaughter Janine is a single parent suffering from anxiety.

As a partnership we are also supporting doctors, nurses and other professionals, including social care and mental health, to work in teams around GP practices so Janine can get help locally; for example, through our new primary mental health service. Supporting Janine to stay well will also ensure her daughter gets a better start in life.

And because of our special Devolution agreement, which gives us more local responsibility for how we spend our money, we have access to extra funding to invest. For example more specialist diabetes nurses who can support people like Mary both in hospital and at home.

Through initiatives like these, making the most of our freedom to spend money as we think best, organising teams as locally as possible and listening and working with residents, we will be able to help Surrey people live healthier lives and improve the health of the generations to come.

How we are organising ourselves differently

We know people like Mary and her family don't wear a single badge. They don't just have diabetes, anxiety or feel socially isolated. Yet the current system can be confusing, and isn't always focused on people's complete needs.

There is an increasing national drive for health and social care to work in partnership – across organisational boundaries and in mixed (multi-disciplinary) teams – to put individuals at the centre of decisions about their care and support. We know this brings real benefits for patients – including promoting independence and improving quality of life - and is a key focus in the new NHS Long Term Plan.

As we move towards this more joined up way of working we have been thinking about which services we should plan across larger areas (for example across Surrey or beyond – areas like mental health and children's services), and those that are better delivered at local level, through our local partnerships called Integrated Care Partnerships.

Our unique Devolution Agreement

In June 2017 we signed a unique devolution agreement with our regulators – NHS England and NHS Improvement - which means we have more direct control of our funding for health and social care, and on how we spend it. This gives us the freedom to make more decisions locally, and has given our partnership access to some additional funding which we've invested in local improvement projects.

Surrey-wide Services

The following four areas have been agreed by the partnership as priorities for planning and delivering on a Surrey-wide basis from April 2019:

- Mental health
- Learning disabilities and autism
- Continuing healthcare
- Children's services.

This is about agreeing how we will spend our money to deliver these services across Surrey, with local engagement continuing to play a really important role.

Integrated Care Partnerships

Integrated Care Partnerships (ICPs) are groups of local health and care organisations, also including borough councils and voluntary/community sector members, working across the existing Clinical Commissioning Group geographies (Guildford & Waverley, North West Surrey and Surrey Downs). Each ICP is developing its own priorities, reflecting the different needs of each local population, and thinking about how they will work differently in the future. Common themes are emerging, for example there is more emphasis on wellbeing and prevention and on breaking down the barriers between organisations.

Primary Care Networks

Primary Care Networks (PCNs) are groups of local GPs and other partners operating at a very local level to plan and buy care for local populations of generally between 30,000 and 50,000 people, and will be able to buy and/or provide a wider range of services across their combined patient populations. We now have 18 Primary Care Networks across Surrey Heartlands who are starting to draw up their detailed plans.

You can see a selection of Frequently Asked Questions on the ICS, ICPs and PCNs at surreyheartlands.uk/frequently-asked-questions.

A new health and wellbeing strategy for Surrey

In Surrey we have also been working with our other public sector partners to develop a 10 year strategy that all partners can sign up to. This new Health and Wellbeing Strategy provides the framework for all our plans and is overseen by the Surrey Health and Wellbeing Board.

The strategy sets out three key priorities that will help us deliver the wider NHS Plan ambitions and reduce health inequalities, and is particularly focused on what we can achieve together, as a wider partnership. These are:

- Enabling people in Surrey to lead healthier lives;
- Enabling the emotional wellbeing of people in Surrey; and
- Enabling people in Surrey to fulfil their potential.

Working together with all our partners – across Surrey or more locally – is putting us in a much stronger position to tackle the other factors that affect health – things like housing, the environment, education – so we can create a real and lasting change for the next generation.