

Joint Forward Plan

2023 - 2028

FINAL DRAFT – EXECUTIVE SUMMARY

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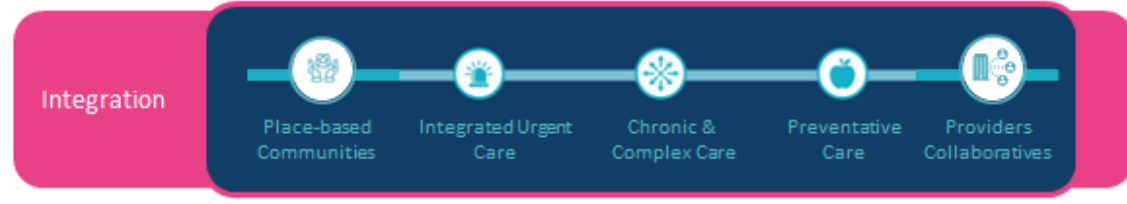
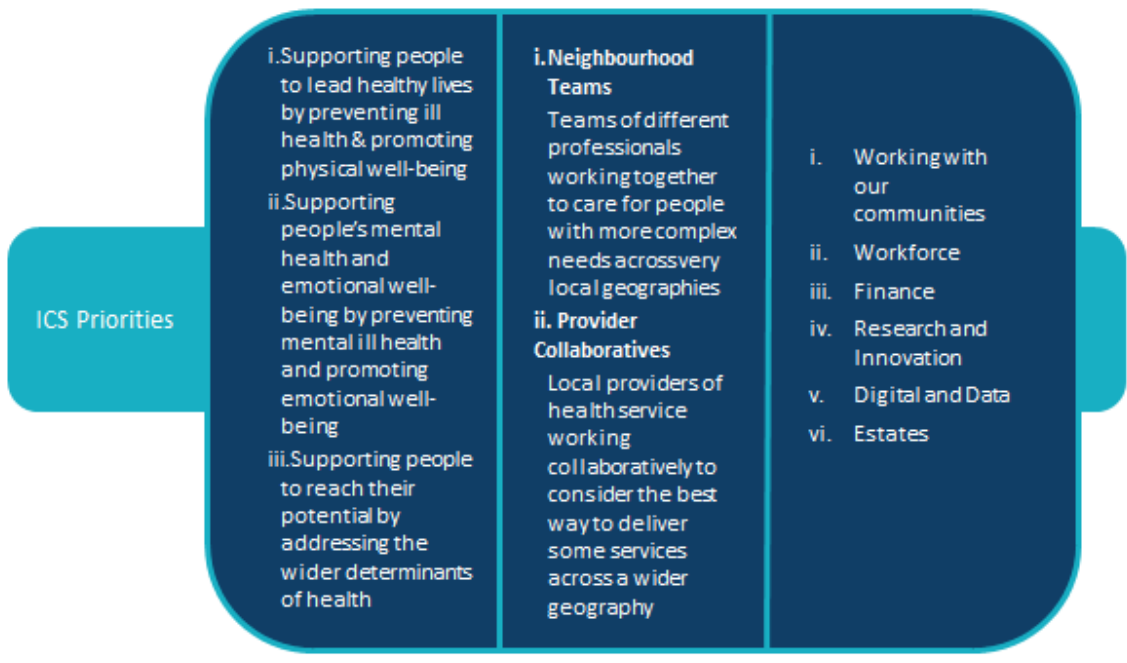
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One System, One Plan – On A Page

Vision
By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.



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Executive Summary

Only by taking a collective responsibility across our partnership will we be able to achieve the step-change in outcomes, for all our communities, that we want to see.

Our [Integrated Care Strategy](#) describes how we intend to meet the health and wellbeing needs of local people; building on existing collaboration. This is about promoting the right partnerships – at System, Place and Neighbourhood level – that will lead to improvements in health and wellbeing and the socioeconomic conditions of local people. Our strategy reinforces the importance of prevention and keeping people well, as the major catalyst for change.

The strategy is based on **three ambitions** that reflect where we are and what our populations have told us, so that 'no-one is left behind'. These set out our key areas of focus with significant emphasis on reducing inequalities.

- A. **Prevention**
- B. **Delivering Care Differently**
- C. **What we need to deliver these ambitions**

This our first Joint Forward Plan. We describe how we will move towards realising our [vision](#) for people's health and wellbeing and start delivering our strategy. It builds on work already underway through the ['Community Vision Surrey in 2030'](#) and the ['Surrey Health and Wellbeing Strategy'](#), focusing on the prevention of ill health and the greater integration of health and care services including the wider public and voluntary sectors, reflecting the NHS Mandate and what local people are telling us. It sets out how we will deliver local health and care services alongside broader care delivery, focusing on **Years One and Two** of our strategy.

We know that **clinical care alone** only makes around a [20% contribution to health and wellbeing](#) with a 30% contribution from **individual health behaviours**; the rest (the **wider determinants of health**, excluding genetic and hereditary factors) is influenced by things such as education, housing, employment, and the environment.

This plan describes our strategic delivery plans through our wider partnerships and the work we are doing across our four Places and local neighbourhood teams, shifting the focus from treating sickness to collectively using our resource to focus on prevention and keep people healthier. Positive intervention in a child's life represents prevention in their life as an adult, interventions which should be made at the earliest opportunity from pregnancy onwards.

We will put greater focus on prevention and targeting support where it's most needed:

- Working proactively with our communities to support people to lead healthy lives,
- Providing more personalised care,
- Working together to offer a wider range of support closer to people's homes.

In doing so, we will achieve the ICS four purposes:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Overall our health and care needs are changing, our lifestyles are increasing risk of preventable disease and affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing. [Population Health Management](#) helps us understand – at system, 'Place' and neighbourhood - current health and care needs, creating informed predictions of what people need to help prevent ill health. We will increase personalised care, designing more joined-up services and incorporating our [working with](#)



[communities principles](#), to make best use of our collective resources and improve people’s overall health and wellbeing.

Through social research and local insight, we know our combined efforts are making a difference. For example, improved access and communication to and from primary care, greater experience of personalised care and improved experience of integrated adult social care. Local people have highlighted common themes to inform our ambitions, including the need for more health and care integration, better access to services and the importance of supporting our valued workforce.

These strategic ambitions are a key part of our [One System, One Plan](#) framework – a single view of transformation and recovery which is reflected in the plans and strategies of all partners. Embedded within these is the vision from the [Fuller stocktake](#) to:

- streamline access to care and advice for people and ensuring care is always available in their community when they need it
- provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs
- help people to stay well for longer as part of a more joined-up approach to prevention.

To achieve our ambitions, we need to create **the right conditions for success**. This includes how we work with communities enabling them to lead locally driven change, involving and listening to what people are telling us, progressing digital ambitions and use of data, and developing a workforce with the right culture, skills, training and leadership.

Our Trust Provider Collaborative, to be formally established in summer 2023, will work together, as experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability.

In 2028, when we have delivered this plan, our population will benefit from the [priority outcomes](#) detailed in our strategy and experience:

- Increased services **focusing on prevention**, providing communities with the right access to preventative support.
- **Integrated Neighbourhood Teams** shaped and designed by partners from across the health and care spectrum – statutory, voluntary, community and social enterprise organisations.
- **Improved access to same-day urgent care and general practice**, enabling Neighbourhood Teams to take an active role in **creating healthy communities** by working with local people, and developing closer relationships with local authorities, voluntary and community sectors.
- **Streamlined access to integrated urgent, same-day care and advice** from expanded multi-disciplinary team, using data/digital technology to find patients the right support.
- Our ‘Team of Teams’ will **have the physical space to work together** in their neighbourhoods
- Multidisciplinary teams with **new skills and capabilities**, through successful recruitment, retention and learning to support the communities they serve.
- **Digital technology and data** underpinning how our teams work, how our communities interact with us and how we analyse and use data to continuously improve services.
- **Health on the high street** driving town centre reimagination through our health diagnostic offer and positive economic impacts driven by the ICS supply chain helping to deliver sustained socio-economic outcomes.

Over **the next two years**, we will also deliver against the national NHS priorities:

Recovering services & productivity	Urgent and emergency care	Delivering transformation & LTP ambitions	Learning disabilities & Autism
	Community adult and children’s health services		Improve health and reduce inequalities
	Primary care		Invest in our workforce
	Elective Care, Diagnostics, Cancer		Use of collective resources; Continuing Health Care, Medicines Optimisation, ICS running costs, Workforce and Agency Spend
	Maternity, neonatal & children’s services		
	Mental health		



Across these priorities we will be considering what we do at an individual level to provide more preventative and personalised care, how we work within our neighbourhood teams, across our larger Place partnerships and the wider health and care system.

We will focus on prevention and tackle what will make the most difference to people's lives **over the next three to five years** by continuing to **integrate primary care services**; bringing together general practice, community pharmacy, dentistry and optometry, alongside other health services and personalised care for people and families, where they live.

Above all, we need to be bold in our approach, leveraging our collective efforts as partners to transform what, where and how we provide care and work with local communities so they can take more control of their own health and wellbeing.

The deliverables set out in this plan are based on what needs immediate attention, and for which funding in the coming year has been identified. Year one of the plan therefore contains the most detail. Other schemes may require business cases to be developed, to seek additional funding, before they can be delivered. We describe longer term aspirations (3-5 years) as ambitions. These will be reviewed each year when this plan is updated and future funding allocations are confirmed.

Our wicked problems

We are operating in a financial landscape that is challenged and is not likely to get easier in the near future. We consider the most effective way to address these financial constraints and improve outcomes is the closer integration of health and social care, with less reliance over time on large hospitals and traditional care models, to sustainably address health inequalities.

- **How we focus activity and funding on prevention and tackling health inequalities** in a challenged operational and financial landscape.
- **Social care demand and complexity has overtaken funding levels**, resulting in higher acuity for those admitted and greater difficulty in discharging from acute settings.
- **An older population** – Surrey has 20% more people aged 80+ than the rest of England meaning a large frail population with greater needs and complexity.
- **Recovery from the Covid19 pandemic** – high volumes of planned and emergency care following the pandemic, including delays in care and presentation.
- **Fragmented acute landscape** – high number of hospitals resulting in duplication and smaller scale operations, plus multiple middle- and back-office functions and non-consolidated estate.
- **Over reliance on private sector** – high number of non-NHS independent providers undertaking high margin cost activity, removing private revenues from the ICS.
- **Lack of specialised care, compounded by proximity to London** – due to lack of highly specialised care in the ICS, alongside ease of access to London and other areas, a large proportion of activity occurs outside the ICS (£247m London spend 2021).
- **Funding for increased mental health conditions prevalent locally** – we receive less funding from national allocations, based on assessment of low complexity and need in our population, due to focus on psychosis, and less consideration for other conditions (like eating disorders) where we have higher prevalence.
- **Supporting other areas** – providers serve multiple ICSs including Frimley, Kent and Sussex.
- **Our workforce capacity is concentrated in acute settings, with more scarcity in community, primary care and social care partners**, meaning we don't have the right people in the right place to deliver the models of care we aspire to.
- **Surrey cost of living, access to affordable accommodation, variable education provision within the county and inflexible working options** add further hurdles to building an effective workforce supply.
- **Running cost reductions** – achieving success while streamlining workforce and other costs.



- **System Flow** – high levels of demand and reduced capacity in care settings and effective discharge result in longer patient journeys through our system and challenging environments for our workforce.
- **System maturity** – whilst we have good relationships across our partners, and bold ambitions, we have variable maturity in how we work together to transform, integrate and manage our services day to day.
- **Addressing access and continuity of care** – we continue to see service users experiencing challenges and delays in accessing some services and fragmented care.

Building On Our Successes

We have seen many achievements despite the challenges of the pandemic (**Error! Not a valid bookmark self-reference.**). Using our collective strengths and assets, we will measure success through our 2028 achievements, performance measures, plus patient and user experience.

- **Prevention** - [Growing Health Together](#) in East Surrey invites people living and working in communities across East Surrey to collaborate and co-create conditions in which everyone's health and wellbeing can flourish.
- **Equality, Diversity & Inclusion** – Supporting ethnically diverse women in Maybury and Sheerwater to gain activity qualifications, empowering them to become role models for physical activity in their community. We are also actively using Black and Minority Ethnic experiences to improve workplace, service standards and culture development.
- **Maternity** - Perinatal mental health service now in place, alongside a '[Baby Buddy](#)' app providing daily tips/advice on lots of topics for families with children up to 1 year old.
- **Technology** – With Mole Valley Life, First Community's Responsive Services have supported the installation of emergency lifeline alarms and key safe boxes for residents, helping them feel safer when the team or their family aren't around.
- **Supporting Surrey's Carers** - Five new carer support hubs located within communities including improved tailored support for young carers (HSJ awards finalists).
- **Pioneering Cancer Treatment** - Artificial intelligence-led project at Royal Surrey hospital improving cancer care - 'Ethos' targets radiotherapy with precision avoiding damage, limiting side effects and tailoring to changes in patient's bodies.
- **Clinical Research** – Surrey and Sussex Healthcare NHS Trust awarded best Clinical Site Team in the Pharma Times International Clinical Researcher of the Year Awards, June 2022, for their demonstration of excellence in setting up and conducting research trials.
- **Improving Emergency Care** - The Emerge Project at Ashford and St Peter's Hospitals, with the [East to West](#) charity, has supported hundreds of vulnerable young people coming to the Emergency Department in a mental health crisis, with wider care in the community.
- **Personalised Care** - Surrey Heartlands published a joint [Palliative and End of Life Care Strategy](#) where everyone is seen as an individual, with care tailored to meet their needs.
- **Social Care** – 94.1% of adults receiving adult social care feel safer, enjoy better quality of life, with greater control over their daily lives (above the national and Southeast average).

Figure 1 – highlights from Surrey Heartlands

This Joint Forward Plan (JFP) sets out how we will deliver our strategic ambitions over the next five years:

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|-----------------|---|
| ▪ Introduction | About Surrey Heartlands |
| ▪ Chapter One | Ambition 1: Prevention and Keeping People Well |
| ▪ Chapter Two | Ambition 2: Delivering Care Differently |
| ▪ Chapter Three | Ambition 3: What we need to deliver these ambitions |