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Surrey Heartlands

Joint Forward Plan

Summary

DRAFT v1.7

12 June 2023

Please note, this is a plain text version of the summary plan, which will be designed-up for publication, with photos, maps and other images added.

The document is designed to be read across two pages, like a book or magazine. If read on screen, it will work best if viewed across two pages.

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Inside front cover

ACKNOWLEDGEMENTS

This document has been created by Surrey Heartlands Integrated Care System in partnership and with collaboration from:

- The **citizens of Surrey and their families**, Surrey Carers Partnership Board

- **NHS and social enterprise partners:** Ashford & St Peter's Hospitals NHS Foundation Trust; CSH Surrey; Epsom & St Helier University Hospital NHS Trust; First Community Health & Care; Royal Surrey NHS Foundation Trust; South East Coast Ambulance Service NHS Foundation Trust; Surrey & Borders Partnership NHS Foundation Trust; Surrey and Sussex Hospitals NHS Trust, NHS Surrey Heartlands Integrated Care Board, our 104 GP practices who work as part of 25 primary care networks; six GP Federations

- **Local authority partners:** Surrey County Council, Elmbridge Borough Council; Epsom & Ewell Borough Council; Guildford Borough Council; Mole Valley District Council; Reigate & Banstead Borough Council; Runnymede Borough Council; Spelthorne Borough Council; Tandridge District Council; Waverley Borough Council; Woking Borough Council

- **Voluntary and Community Partners,** Healthwatch Surrey; Surrey Voluntary, Community and Social Enterprise (VCSE) Alliance

- Our **Independent Providers**

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ABOUT SURREY HEARTLANDS

The Surrey Heartlands Health and Care Partnership is a partnership of organisations that have come together to plan and deliver joined up health and care services, and to improve the lives of people who live in Surrey. Having a clear strategy in place is vital and allows us to focus on how best to meet the health and wellbeing needs of people in Surrey and reduce the inequalities we know currently exist.

We know that clinical care alone only makes around a 20% contribution to health and wellbeing, with a further 30% from individual health behaviours; the rest is influenced by factors such as education, housing, employment and the environment.

As a health and care partnership we want to work with our communities to harness local innovation, so residents can access the right support that's developed from the ground-up, with joined up health and care services that make the most of digital technology.

With a focus on prevention and support that is targeted where it's most needed, we will reduce the unfairness some people experience in accessing care, so nobody is left behind.

Our health and care partnership (also known as an Integrated Care System) is made up of an Integrated Care Board, Integrated Care Partnership, four Place-based Partnerships and local neighbourhoods – more detail is on our website.

www.surreyheartlands.org

MAP

Place-based partnerships

Partnerships of health, local government, the voluntary, community and charity sector with wider partners across local populations of around 250,000 – 300,000.

Neighbourhood teams

Teams of different professionals working together to care for people with more complex needs across very local geographies.

The Fuller Stocktake

Our Chief Executive, Professor Claire Fuller, led a national review looking at primary care - general practice, community pharmacy, dentistry and optometry - to identify what was working well and why.

The resulting 'Next steps for integrating primary care: the Fuller Stocktake' sets out a vision to improve access, experience and outcomes for people and communities.

Reflecting our vision for greater integration of local services, the recommendations centre around three essential areas:

- Streamlining access to care and advice
- Providing more proactive, personalised care
- Helping people to stay well for longer

Our Vision

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Our vision is to work collaboratively with people and partners across Surrey Heartlands to improve long-term health and care.

The recommendations in the Fuller Stocktake reflect our vision for greater integration of local services and to act on what matters most to our communities, namely:

- making it easier to access the care that they need when they need it and;
- creating the space and time for our clinicians to provide the continuity of care that is so important to our patients.

WHAT YOU TOLD US

During Autumn 2022, we held several social research and public engagement sessions around Surrey to ask you, our residents, about your priorities and thoughts about the NHS and health and care services. We heard about the challenges experience, what is working well as well as your expectations and opportunities for improvement.

Accessing healthcare

You told us that you continue to struggle with making contact with or accessing services. Being directed to online services with long waiting times can be confusing and act as a barrier. We also heard that more frequent and proactive communications from service providers would help you to feel more confident and in charge over your health and care journey.

> "*Your referral is in a cloud and you don't know what's happening. No communications, no transparency on where you're at. You need to be proactive and chase constantly because there's nothing coming from them. It's the same with the GP. But the thing is, you know there's an issue with waiting times. All you need is communication and transparency about this."*

> *"Our expectations and way of life is not suitable for the NHS. We want everything immediately… has to be instant. We expect much more. But as it is, the NHS can't meet these expectations, because this is not a functional NHS. The system can't cope with this."*

Continuity of care

You told us that lack of staff and investment in the health and care workforce negatively impacts the experience received and too often care is fragmented and has to be repeated or delayed.

Patient L told us that community care following her hospital discharge was insufficient.

She couldn't access support from district nurses as frequently as indicated upon discharge. She felt there was a lack of communication between the hospital and community services. Her husband spent a long-time making calls to different providers to follow up on their requests and questions about things such as equipment and home visits, as no single agency seemed to have overview and ownership of her care.

> *"Can't fault the care…current problems are about the system, not the quality of care."*

> *"It is not the consultant's fault. The management and processes are broken."*

> *"The hospital is short on staff, there aren't enough people to look after patients. That's why I come here every day to look after my mother. There are not enough mature nurses. A lot of the staff are temporary and inexperienced and burdened".*

Proactive approach to care

You agreed that proactive, personalised care supports your longer-term health and care needs.

> *"It's prevention rather than cure... this is how things should work. And that's what I received."*

> *"I felt people really listened to me. They supported me when I decided to give birth that way. The doctors and nurses listened to me, and made it happen. It was a very personalised experience".*

The voice of our population has been strong and clear; our strategy reflects what we have heard.

OUR STRATEGY

Our Integrated Care Strategy is based on population insights and knowledge gained through our Joint Strategic Needs Assessment, Surrey's Health and Wellbeing Strategy and listening to our residents directly; the voice of our population has been clear and strong, and our strategy reflects this.

Our strategy describes our shift in focus - from treating sickness to focusing on prevention using our collective resources to keep people healthier. We know that positive intervention in a child's life represents prevention in their adult life - interventions which should be made at the earliest opportunity from pregnancy onwards.

To deliver this, our strategy is based on three underpinning ambitions:

1. Prevention
2. Delivering care differently
3. What needs to be in place to deliver these ambitions

Through our wider partnerships and the work we are doing across our four Places and local neighbourhood teams, we are seeking to decrease the pressure on health and care services, reduce waiting times and increase person-centred care.

We are not going to fix every problem overnight. The shift in approach needed – moving to a model where organisations work together as a system to design and deliver care – is significant and will not be without its challenges.

It's not just about transforming how services are delivered on the front line, it's also about realigning all our functions and re-imagining how they can enable our neighbourhood and place teams.

Image/ continuation of Our strategy info

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OUR AMBITIONS

We have developed three ambitions that reflect where we are strategically and what our populations have told us. These set out the key areas of focus we need to take and how we will measure our success against them.

Prevention

Reflecting the three key priorities within Surrey's Health and Wellbeing Strategy we will reduce health inequalities and support our priority populations to:

- lead healthy lives by preventing physical ill health and promoting physical well-being
- prevent mental ill health and promote mental health and emotional well-being
- reach their potential by addressing the wider determinants of health (so things like education, housing, employment).

Delivering Care Differently

Local people have told us they want services that are responsive to their needs and that they are at the centre of decision-making by:

- making it easier for people to access the care that they need when they need it.
- creating the space and time for our workforce to provide the continuity of care that is so important to our populations.

What needs to be in place to deliver these ambitions

So we can be effective and deliver our first two ambitions, there are a number of other functions we need to be working well. This includes how we:

- work with our communities and enable them to lead locally driven change
- progress our ambitions around digital services and how we use data;
- develop a workforce with the right culture, values, behaviour, skills, training, and leadership to face the demands of the future.

We know that if we align our approach through these shared ambitions, we can accelerate the pace of change.

OUR JOINT FORWARD PLAN

Our Joint Forward Plan sets out how our Integrated Care System will work together over the next five years to deliver on:

- **Local strategies**, including the Surrey Heartlands integrated care strategy and Surrey health and wellbeing strategy
- **The NHS long-term plan**, national priorities and constitutional standards
- **Organising and developing** the system
- **Achieving financial sustainability**, transformation and to integrate our delivery model.

Engaging and working with our communities

Our plan aims to address what we have heard from our communities - to improve access, navigation, continuity of care and keep people well across all aspects of our health and care system.

Transforming services in our neighbourhoods and towns

Care and support available in your local area

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- Your local integrated health and care team care team will 'know' who you are
- We will carry out health checks and provide care plans tailored to the individual along with vaccinations and immunisations
- Complex care management will be proactive to prevent further complications
- Support will be given for vulnerable and 'at risk' groups
- We will work together to provide treatment and care closer to people's homes

Transforming services in our four areas (Places)

Care and support in your local district and borough

- Services will be in place that meet the demands of the local area
- There will be multi-professional, multi-agency teams in local communities
- Community urgent care hubs will be available where they are needed

Transforming services across Surrey Heartlands

Organising health and care for the whole of our population.

- We will transform how we use technology and share information across the system
- We will work towards recruiting and retaining more staff
- Our premises will be fit for purpose
- NHS 111 will be main way to access the services needed
- We will improve urgent and same day care with clear alternatives to accident and emergency departments
- There will be a modern and responsive ambulance service

DELIVERING OUR AMBITIONS

Prevention: Supporting people to lead healthy lives by preventing physical ill health and promoting physical wellbeing

We will know that we have succeeded in our ambition when our population can say:

"*I have access to all the information and support I need to remain as independent as possible*."

You have told us that keeping well and living your own healthier life is important. Highlights of our response for **prevention and keeping people well** priority include:

Outcomes for this priority	We are doing
People have a healthy weight and are active.	We will continue to develop the range of support such as **nutrition, physical activities and children's healthy weight** on our Healthy Surrey website.
Substance misuse is low (drugs/alcohol/smoking).	We will be funding Tobacco Dependency Advisors to deliver 'in-house' smoking cessation services across all the acute and maternity services
The needs of those experiencing multiple disadvantages are met.	Surrey's Changing Futures Programme is introducing the Bridge the Gap Trauma Informed Assertive Outreach alliance - joining together to provide a specialist, relational model of **trauma-informed outreach for adults** by helping people to become more self-reliant over time.
Serious conditions and diseases are prevented.	We are developing **Community diagnostic hubs** in communities increase access and early diagnosis for our population. This includes outreach models such as working with the homeless communities who can now access mobile Hepatitis C screening and liver testing as well as Covid vaccinations from an outreach community team.
People are supported to live well independently for as long as possible.	We are increasing accessing **day services and activities** within their local communities helping people stay independent for longer.

Prevention: Supporting people's mental health and emotional wellbeing by preventing mental ill health and promoting emotional wellbeing

Outcomes for this priority	We are doing
Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources.	For children and young people, we will support them through our **Anxiety & Suicide Prevention programme** and tailored services. We will continue our strong partnership working such as HOPE service to **provide help and support, closer to home** through commitment to the iTHRIVE approach. We will have a much stronger focus on early intervention, with mental health support embedded in all our schools and colleges. We will ensure 24/7 adult psychiatric liaison in all emergency departments.
The emotional wellbeing of parents and caregivers, babies and children is supported.	We are extending our **specialist perinatal mental health services** from preconception to 24 months after birth with additional access to psychological therapies in services and addressing the equity of our services for our population.
Isolation is prevented and those that feel isolated are supported.	We know that people may not see themselves as **Carers** or know about support and services to help them. We are focusing on including Carers as part of the patient's assessments so that the entire family – young people and adults, will have ready access to appropriate information and be able to access appropriate support services.
Environments and communities in which people live, work and learn build good mental health.	We will continue to expand green health and wellbeing and social prescribing initiatives that connect people to activities, groups, and services in their community to meet the practical, social and emotional needs that affects their health and wellbeing.

Prevention: supporting people to reach their potential by addressing the wider determinants of health

Outcomes for this priority	We are doing (JFP Delivery example)
People's basic needs are met (food security, poverty, housing strategy etc).	Each of our district and borough councils have an active **homelessness and housing** strategy. Health and care partners are working together to arrange support for those that need it; including older, disabled and more vulnerable residents to live, safe, healthy and independent lives.
Children, young people and adults are empowered in their communities.	Surrey's **Early Support Service for young children with disabilities** will give information about support that is available. We will ensure public and voluntary services work together to support families at the earliest opportunity to become more confident and resilient in the future.
People access training and employment opportunities within a sustainable economy.	We are developing through our **workforce** strategy - United Surrey Talent - a core offer for our people, where everyone on the team has access to the same or equivalent support and reward.
People are safe and feel safe (community safety including domestic abuse, safeguarding).	Reduce the long-term harm and cost of **domestic abuse** in Surrey, with targeted support in our Neighbourhood Teams for our priority populations - Surrey Against Domestic Abuse.
People benefit from healthier environments (including through greener transport/land use planning).	We are working to move to low carbon inhalers for asthma and COPD where appropriate, as part of care quality improvements for **respiratory care**. We will continue preventative support to reduce the prevalence of smoking and increase in electric vehicles in the NHS fleet.

Delivering Care Differently: Improving access, navigation and continuity of care

We will know that we have succeeded in our ambition when our population can say:

"*I have care and support that is coordinated, and everyone works well together and with me.*"

You have told us that improving access, navigation and continuity of care will be most impactful to your experience and health and care outcomes. Our second priority then, is to **deliver care differently**.

Outcomes for this priority	We are doing
When every person can **access** care easily, efficiently and receive the help and support of their choosing.	Roll out of **advanced telephony systems in general practice** to increase ease of access and effective use of online consultations. This will enable seamless service flow and re-direction by offering 'call-back' functions to enhance people's experience and aid clinical decision making – in and out of hours.
When people who want **personalised care,** receive it through multi-disciplinary teams and care coordination.	We will continue to work with individuals, health care professionals and referrers to ensure they have the relevant information to **support choices about care and treatment**. In primary care, we will seek to implement delivering care from a named health or care professional.
People should experience a reduction in unplanned attendances to emergency/urgent care services, the number of times they need to contact their GP practice and visits to other health services.	Our **diabetes** programme will empower our citizens to manage their diabetes or reduce their risk by raising awareness, providing quality education programmes and reduce variation in care provision and clinical outcomes. This will increase people taking an active role in managing their condition and aims to reduce hospital admissions particularly for cardiovascular and renal disease.

What needs to be in place to deliver our ambition: Functions that need to work well

We will know that we have succeeded in our ambition when our population can say:

"*I am able to access care in an environment which is appropriate to my needs with the right facilities and supporting information both I, and my care professional, need*."

So we can be a mature, productive and effective system and deliver our ambitions, there are a number of other **functions we need to be working well**. This is our third ambition.

Outcomes for this priority	We are doing
Working with our communities to create more opportunities for collaboration with partners at neighbourhood level.	We will continue developing and our local community engagement groups for citizens and staff, using learning from existing multi agency, neighbourhood assemblies to co-design healthier communities and supporting communities to lead the way and supporting people to take more control of their health and wellbeing.
A **workforce** with the right values, behaviours, skills, training and culture across all partners organisations.	We are creating a new Health & Social Care Academy for **learning and education** across our 40,000 staff and students in our local colleges and higher education.
Our workforce benefits from systems **leadership**/skills, educational and development opportunities.	Our leaders will need to work across organisational boundaries at both local and county levels and through our pioneering a new "**Growing System Leaders**" programme, will help key people develop their stewardship skills.
Health and social care services are delivered in the right, **fit for purpose space and conditions** to support communities.	Our **Integrated Estates Strategy** will bring flexible integrated health and care estate that enables the right services to be delivered; relieve pressure on acute settings, provide a more agile way of working for staff, and help to reduce inequalities and improve access to the right settings.
A highly **digitally** skilled workforce, using digital technologies with a digitally empowered population able to manage their own care.	We will continue to use and scale the use of **remote monitoring tools** and applications such as blood pressure monitoring service 'BP@Home', urine tests, Children's e-Red book, My COPD. We will support the digitisation of 600 local health and care settings – social care and care homes - to improve citizens outcomes through coordinated and connected professional teams.

Outcomes for this priority	We are doing
Data sharing across systems and partner organisations to improve health and care outcomes	Our **Integrated Digital and Data Platform** (IDDP) will provide an integrated central data system to drive Population Health Management goals, support the Surrey Care Record and Personal Health Record through state-of-the-art business intelligence and advanced analytics.
Innovation and research is used to maximise outcomes and faster recovery to our population.	With the support of the Allied Health Science Network (AHSN) and wider system partners, we will make Surrey Heartlands the destination of choice to trial and scale research and innovation. And develop a strategy that will attract industry investment to support delivery and development of novel solutions for the benefit of our population.
Finance	We will agree a system wide single procurement approach to maximise value for money and best use of collective resources within Surrey Heartlands and associated wider partners.

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NEXT STEPS

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. We believe we have a strong plan to deliver this change.

We will know we are succeeding when we can see that:

- **Access –** every patient is able to access primary care easily, efficiently and receive the appointment type of their choice.

- **Continuity** – there is an increase in personalised care being provided by multi-agency, multi-disciplinary teams with care co-ordinators, enabling patients to see the same clinicians or teams.

  We will see a reduction in the number of emergency department attendances for defined groups of patients, an overall reduction in the number of GP contacts and outpatient contacts.

- **Approach to care –** groups of patients identified with clear inequalities in terms of life expectancy, immunisation and screening, diabetes and cardiovascular prevention get the right care and support to meet their needs.

  We should also see populations who aren't routine health seekers receive early cancer diagnosis**.**

The Joint Forward Plan will be reviewed and published annually by 1 April up to 2028 as required by the Health and Care Act 2022.

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