Joint Forward Plan

2023 - 2028

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V4.2

12 June 2023

Purpose

The Joint Forward Plan sets out how our local NHS, partner local authorities, voluntary, community and social enterprise (VCSE) sector, our Places and Neighbourhoods will deliver the **ICS strategy** and **NHS Long Term Plan** commitments for our local population over the next five years.

The Joint Forward Plan describes how we will:

- **Deliver on local strategies**, including the Surrey Heartlands Integrated Care Strategy and Surrey Health and Wellbeing Strategy
- **Deliver NHS specific ambitions**, including the NHS long-term plan, planning guidance priorities and constitutional standards
- **Organise and develop** the system to deliver on these ambitions
- **Work together to achieve financial sustainability**, transformation and to integrate our delivery model.

We face significant **financial challenges.** Surrey Heartlands Health and Care Partnership is working together to achieve financial sustainability for our system, as we integrate and transform our ways of working.

The creation of this document reflects the legislative requirements of the Health and Care Act 2022 in relation to system Joint Forward Plans.

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Acknowledgments

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**

Review Date: January 2024

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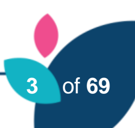

Foreword

We all want people in Surrey to live in good health for as long as possible and that they are supported to 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 most health and care providers rated good or outstanding.

However, there are big differences between what most of us experience and what some of us can expect, with up to a 12-year gap in life expectancy depending on where you live. 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. We also know that clinical care alone will only ever impact about 20% of someone's health and wellbeing; the rest is influenced by factors such as education, housing, employment, the environment and hereditary factors. Which is why it's so important for organisations to come together to tackle these wider issues collectively.

Surrey Heartlands is a formal partnership of health and care organisations working together to do just that. This means health organisations, the local authorities and others taking collective responsibility for improving the health of the local population, managing resources (including money) and delivering high quality health and social care. Doing this in partnership gives us much greater scope to have real influence on people's health and wellbeing in ways we couldn't if we simply focused on fixing symptoms rather than the wider causes of poor health.

In Surrey Heartlands we want to create a health and care system that builds on the amazing community spirit we witnessed during the pandemic. One that values the role of the local community and organisations, focused particularly at the most local, neighbourhood level, enabling people and families to take more control of their health and wellbeing, with easy access to high-quality care when it's needed.

By 2028, we will have put greater focus on prevention and targeting support where it's most needed, so no-one is left behind.

At the same time, we want to take advantage of what we have in Surrey to pursue innovation with business, public sector partners and communities, joining up services for residents and developing digital technologies to create smarter ways of managing health and accessing support.

The creation of statutory partnerships – known as Integrated Care Systems - via the Health and Care Act 2022 - has given us the right framework to make this step-change and the opportunity to make genuine long-lasting change through delivery of our new Integrated Care Strategy. At a critical time of rising demand for services, the need to reduce waiting lists, improve access and continuity of services, we have the mandate to work differently and create the transformation that's needed to improve people's health and wellbeing and provide sustainable, high-quality services into the future.

This document sets out how we plan to do this over the coming years, working in partnership with both our workforce and local people, to continue to support the people of Surrey Heartlands to live healthier lives. We face significant financial challenges as our partnership works together to achieve financial sustainability, transformation and to integrate our delivery model across our four Places.

This is our first Joint Forward Plan. It will be refreshed by the end of March each year reflecting the evolution and maturity of our plans.

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Health and Wellbeing Board Statement

ADD OPINION OF PLAN – Board 21 JUNE 2023

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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.

ICS Strategy

A	B	C
Prevention	Delivering Care Differently	Functions in place to deliver these ambitions

ICS Priorities

A	B	C
i. Supporting people to lead healthy lives by preventing ill health & promoting physical well-being ii. Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being iii. Supporting people to reach their potential by addressing the wider determinants of health	**i. Neighbourhood Teams** Teams of different professionals working together to care for people with more complex needs across very local geographies **ii. Provider Collaboratives** Local providers of health service working collaboratively to consider the best way to deliver some services across a wider geography	i. Working with our communities ii. Workforce iii. Finance iv. Research and Innovation v. Digital and Data vi. Estates

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Our Critical 5

1. Keeping people well and redesigning urgent care pathways
2. Safe and effective discharge
3. High risk care management
4. Effective hospital management
5. Surrey Heartlands wide efficiencies

Integration

- Place-based Communities
- Integrated Urgent Care
- Chronic & Complex Care
- Preventative Care
- Providers Collaboratives

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.

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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

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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
	Community adult and children's health services
	Primary care
	Elective Care, Diagnostics, Cancer
	Maternity, neonatal & children's services
	Mental health

Delivering transformation & LTP ambitions	Learning disabilities & Autism
	Improve health and reduce inequalities
	Invest in our workforce
	Use of collective resources; Continuing Health Care, Medicines Optimisation, ICS running costs, Workforce and Agency Spend

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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.

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- **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

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

- 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

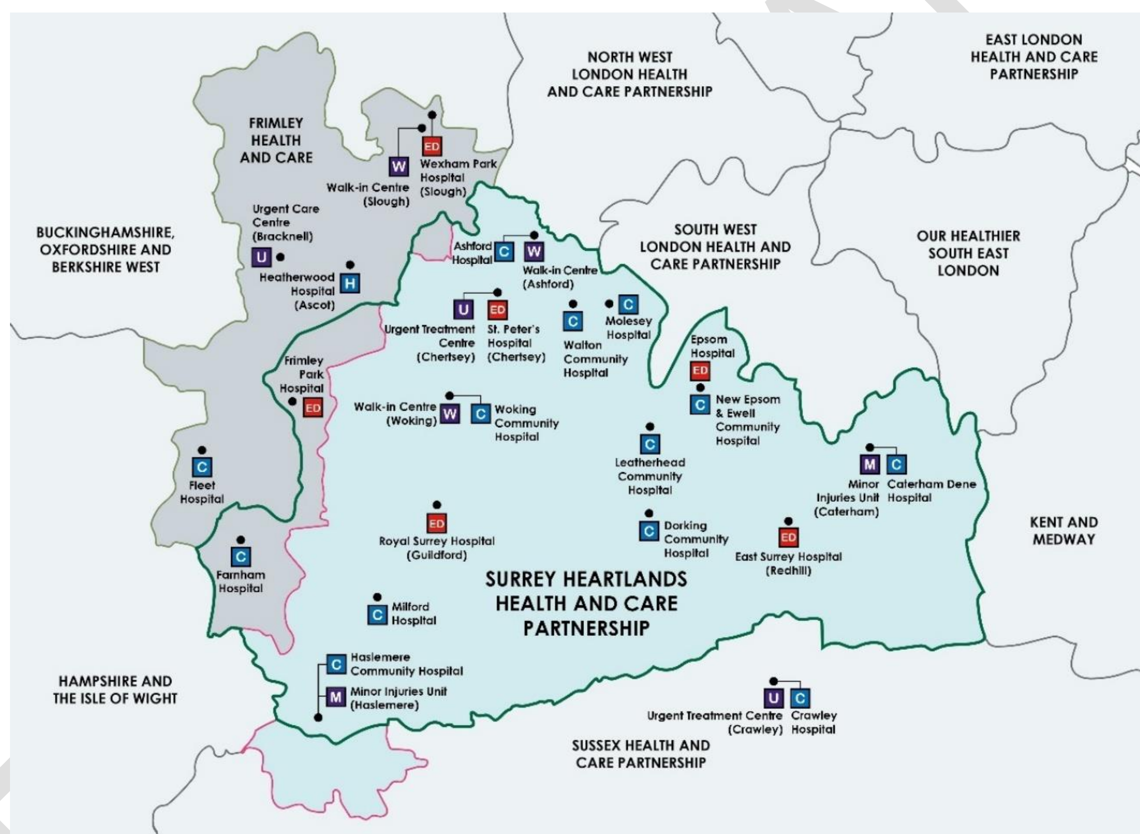
Introduction: About Surrey Heartlands

Surrey Heartlands Health and Care Partnership is an 'Integrated Care System' (or ICS for short). That means we take collective responsibility for improving the health of the local population, managing resources (including money) and making sure services are high quality.

Our partnership covers most of Surrey, a population of around 1.2 million, as shown in the map below. The rest of Surrey (including the borough of Surrey Heath and parts of Farnham) are covered by the Frimley Health and Care system. We have long standing partnerships and collaboration with neighbouring health and care systems, from Southwest London to Hampshire.

As a partnership we want to create a health and care system that builds on the amazing community spirit we've witnessed during the pandemic. One that builds trust and relationships with communities and supports people to take more control in their lives and in their communities, with easy access to high-quality care when it's needed.

You can read more about how we developed leadership and accountability across our system partners in the Surrey Heartlands' Development Plan (2022) and governance in appendix 1.



The Population We Serve

The health of people in Surrey is generally better than the England average. Surrey is one of the 20% least deprived counties in England, however about 9.1% (18,310) of children live in low-income families. Life expectancy for both men and women is higher than the England average.

We know that in our community we still face challenges:

- Implications of covid has impacted on **school readiness** including speech, language and communication and increased anxiety.

- There is a **12-year gap in life expectancy for females and 10 year gap for males** depending on where you live in Surrey Heartlands. Access to care is not always the same for our communities.
- Surrey is rural place with limited transport links therefore access to care is not always the same across our communities.
- We have an **aging population**. 2018 predictions estimate the population in Surrey will increase from 1,189,934 in 2018 to 1,227,467 in 2043. This prediction suggests the older population will increase. The increase in the population groups aged 45 and over in Surrey is likely to impact more on health and social care services due to increased risks of developing long term conditions and other needs.
- We have more people than we have seen before **living with ill health and conditions** such as dementia, and loneliness **together with higher acuity**.
- Our populations have told us that the **Cost of Living Crisis** is a significant cause of concern which has the potential to lead to poor health outcomes for them, such as the impact of social isolation on mental health or not having a warm place of residence impacting on long-term condition management. Just over a quarter (26.4%) of the population are economically inactive, of which 2% **are long term sick or disabled** and 12.9% are retired.

Drawing on our Joint Strategic Needs Assessment (JSNA) and population health management approach, we will focus in prevention and support where it's most needed. The Pandemic highlighted the urgent need to prevent and manage ill health in groups that experience **health inequalities – differences in health that are avoidable** - and the unsustainable increase in demand on public services. We know that delays in presentation, postponement of elective care and screening will have led to later presentation of non-Covid illness because of the Covid19 pandemic. The Surrey Community Impact Assessment in 2020 found:

- health impacts were greatest for people aged over 80 and those in care homes,
- those that are not used to needing support have started to struggle,
- there are significant impacts on those already using mental health services,
- more people are participating in unhealthy behaviours such as smoking and alcohol consumption,
- more people felt more isolated.

We will deliver these ambitions through our Surrey Health and Wellbeing Strategy implementation plans and the CORE20Plus5 adults and children programmes, which are described later.

Population Insights

We have backed up these insights by engaging with Healthwatch Surrey, our local providers and the wider community, voluntary and faith sector to understand what local people are telling them directly. Alongside these conversations, we have engaged with local people directly through "on the street" events and Place-specific engagement activities during the development of our plans. People told us about challenges experienced and opportunities to make a difference to the health and care support received:

Access: People continue to struggle with contacting or accessing services. It can be confusing or a barrier when directed to online services with long waiting times.

Continuity: Lack of staff negatively impacts their experience and too often care is fragmented and has to be repeated or delayed.

Approach: People agree that proactive, personalised care supports their longer term health and care needs.

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Working with People and Communities

As we work together to deliver our priorities, we are focusing our approach on the strengths of individuals, community networks and other assets to focus on outcomes rather than a focus on services. Local people have told us they want services that are responsive to their needs and out them at the centre of decision making. Our new model of care can only work if our communities and our staff are able to be equal partners in how services are shaped, designed and delivered.

We will continue to identify specific cohorts who would benefit from proactive care in the community and working with Primary Care Networks (PCN) to refer them to social prescribing or multidisciplinary teams. Our response to the needs of our populations is primarily through these local places; supporting people to become expert patients, developing confidence and responsibility for their own care.

The national programme **CORE20PLUS5** is aimed at reducing healthcare inequalities for adults and children and young people. We have aligned our response to Surrey's Health and Wellbeing Strategy to meet local needs. Our **CORE20** population is made up of four Key Neighbourhoods - the four electoral wards that include areas of deprivation in the national top 20 percent, while our **PLUS** population is composed of two groups; the Key Neighbourhoods and our communities of identity with the poorest health outcomes.

Underpinning this work, we will focus on specific population groups, including the most deprived 20 percent of our population and those people, families and communities experiencing poorer-than-average health access, experience or outcomes, alongside five national clinical areas - **pregnancy, severe mental illness, chronic respiratory disease (COPD), early cancer diagnosis and hypertension** - which we know significantly contribute to life expectancy gaps in more deprived populations.

We are clear that what might work in one neighbourhood may not work in another and we will be guided by clinicians, professionals, voluntary, community and faith partners and the wider community in shaping what each neighbourhood offer looks like. Our Involvement and Participation Framework sets out our strategy for working with people and communities. The implementation of the **Fuller Stocktake Report** and the subsequent development of Place and Neighbourhood teams will drive how care is delivered for populations across Surrey Heartlands.

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Shaping our approach with our communities

Building together

Engaged to build our approach & plan

- In depth qualitative research into access to General Practice
- Citizen panel surveys and qualitative research
- Talked to people in their communities
- Engaging with health and primary care teams, e.g. Guildford
- Covid-19 Community Impact Assessment

Hard-wiring this approach by supporting Places to:

1. Develop and launch full partnership engagement programmes in next 12 months
2. Deliver more community projects supporting local well-being and prevention
3. Share learning and best practices for people involved in community development and health creation

Communication & Engagement

Involving, listening to, and supporting the ongoing participation of local people and staff in the work of the ICB – and our wider health and care partnership - is critical in meeting the health and care needs of our population and tackling the healthcare gaps and inequalities we know exist.

In our **Working with People and Communities** strategy we set out our commitment to this, describing how we will consistently listen and collectively act on the experience and aspirations of local people, communities and staff. This includes supporting people to sustain their health and wellbeing, as well as involving people and communities in developing plans and priorities and continually improving services.

As a system, we have a solid foundation of involving and engaging local people; from strong community relationships, positive stakeholder relationships – with the community, voluntary and faith sector, local borough partners, Patient Participation Groups and elected representatives – and involvement in service redesign, to our citizen engagement programme, cited nationally as good practice in developing our citizen's panel. Our system-wide Involvement and Participation Group, which includes VCSE partners, Healthwatch Surrey, Place representation, members of Surrey County Council's Adults & Health Scrutiny Committee, and other patient and partner representation, provides independent support and oversight for our involvement work and the sharing of best practice.

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Neighbourhoods

- Working with communities at the most local level, creating opportunities for collaboration between all our people, with health and care partners.

Working Across Place

- Developing a local approach across each of our four place-based partnerships including support to work at neighbourhood level, working collaboratively with local partners including health and care partners, the boroughs and the voluntary, community and faith sector.

System

- Setting a strategic approach across Surrey heartlands, with key principles to guide good practise and ensuring the public voice influences and shapes work across our system and is heard at both ICB and ICP level, with overall responsibility for meeting our statutory engagement and consultation duties.

Figure 2 – involving people and communities across our system

We are moving our overall approach away from the more traditional model of engagement to enable genuine co-production and personalised care – tailored to local needs and preferences – as well as a strong reliance on social research and insight to inform decision-making. Working within our Place-based Partnerships and local Neighbourhoods, we are supporting local people to develop a ground-up approach to healthier communities, empowering people to take more control of their health and wellbeing.

CASE STUDY

In Surrey Downs a strong thriving communities programme is focused on redefining how the local partnership works with communities to support people living healthy, fulfilling lives and addressing health inequalities. The local 'Pulling Together' programme has brought together staff and citizens from across the local area to explore the importance of citizen involvement in service design and the opportunities for developing local communities in partnership. Via a series of workshops the programme has looked at the practical steps of how staff and citizens can work together to deliver change and has embedded citizens as part of the programme governance.

We have common involvement principles that we work to across the whole of Surrey Heartlands, actively enacted at local levels through our Place Based Partnerships and local Neighbourhoods.

Key involvement principles

- Putting the voices of people and communities at the centre of health and care decision-making
- Developing trusted relationships to understand people's experiences and aspirations, particularly those most affected by health inequalities
- Building a culture of co-production, insight and involvement – that is meaningful and demonstrating clearly where actions have been taken
- Involving people and communities at an early stage when developing strategies and plans
- Avoiding duplication by understanding and building on insights we already have
- Working in partnership with local communities and going to where people are
- Providing clear, accessible communication/public information

In developing our plans we have listened to what local people are telling us; through ongoing engagement and conversation, targeted engagement programmes which have supported the development of service-specific strategies and through a wider engagement programme during the autumn of 2022 which included a total of 188 in-depth qualitative conversations to understand more about what matters to local people, followed up by a survey of our citizen's panel which generated over 1,000 responses for analysis. Over the next five years we will continue to involve local people as we develop our health and care plans, ensuring their voices are heard and that services are developed around the needs of local people, particularly those experiencing inequalities in care and access.

You can find out more about our engagement programmes and how to get involved on our website.

The way we will work

Since 2017, Surrey Heartlands ICS has been strengthening relationships, promoting equality, diversity, and inclusion and consolidating partner organisation ambitions so we can focus on the wider causes of poor and ill health.

We are taking an increasingly **Place-based approach** to commissioning, partnerships, and service design in order to reflect the unique qualities of Surrey's different towns and villages. These are not statutory organisations, but a way of working with increased collaboration through shared goals.

Our Place-based partnerships cover most of Surrey (Figure 3) and involve the NHS, local government and other local organisations such as voluntary, community and social enterprise sector organisations and social care providers.

Figure 3 – Surrey Heartlands Place-Based Partnerships and Alliances

We have an ambitious programme to drive improved health outcomes for people through the development of strong local partnerships and working with people where they live. We have four Place-based partnerships or Alliances – Guildford and Waverley, East Surrey, North West Surrey, and Surrey Downs bringing together health, local government, the voluntary, community and charity

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sector with wider partners across local populations. Using their local knowledge and relationships, they aim to reduce health inequalities and support delivery of local services across smaller geographical footprints.

Working at a Place level, we use opportunities for our residents, their families, and their communities to be at the centre of our integrated working. Our Place-based partnerships are an invaluable generator of ideas and considerations. In addition to our 'working with communities' commitment, we are committed to developing community assets – using the skills, knowledge, facilities and social networks - to build positive, trusted and enduring relationships with communities.

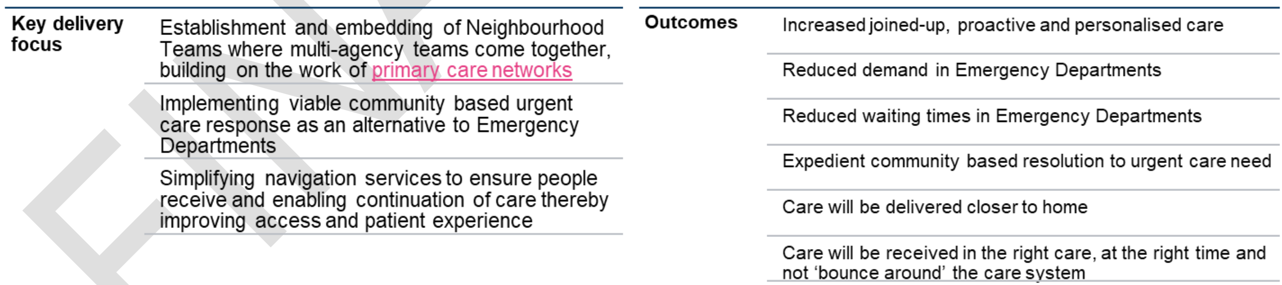
CASE STUDY

North West Surrey Health and Care Alliance are developing a new health campus in Weybridge, which will return health and community services to Weybridge. Our vision is for a state-of-the-art community hub that incorporates a modern, purpose-built health facility, fit for the 21st century, providing a range of high quality health and wellbeing services for the local community by the end of 2025.

This is a partnership between Surrey County Council, NHS Surrey Heartlands and Elmbridge Borough Council, with the development of the health campus as phase 1. We anticipate the facility to include:

- Doctors, nurses and therapists working together to provide a one-stop shop for local health services
- Flexible space and room for expansion so we can respond to population growth and meet future needs
- Access to 'on-the-day' urgent care provided by nurses, GPs and a range of health professionals
- Ultrasound and blood testing services on site
- A range of children's services including 0-19 Health Visiting and School Nursing Hub, as well as Speech & Language/Physical Therapy

Each of our four Places has identified its local priorities to deliver the ICS ambitions. These reflect the diverse needs of their specific populations and thinking about how they will work differently in the future to achieve. Figure 4 shows our Places' the combined key delivery focus and outcomes. You can read more about how we will locally deliver the One System, One Plan in each Place on our website.



Key delivery focus	
	Establishment and embedding of Neighbourhood Teams where multi-agency teams come together, building on the work of primary care networks
	Implementing viable community based urgent care response as an alternative to Emergency Departments
	Simplifying navigation services to ensure people receive and enabling continuation of care thereby improving access and patient experience

Outcomes	
	Increased joined-up, proactive and personalised care
	Reduced demand in Emergency Departments
	Reduced waiting times in Emergency Departments
	Expedient community based resolution to urgent care need
	Care will be delivered closer to home
	Care will be received in the right care, at the right time and not 'bounce around' the care system

Figure 4 - Key Place-Based focus over the next two years

Neighbourhood Teams

We will make neighbourhoods 'real' for residents. This is critical to the establishment of all neighbourhoods. It is where communities will come together at a local level to shape and integrate services which address both the wider determinants of health and health delivery. These include community organisations and primary care services which work together in a small local area with Primary Care Networks to form Integrated Neighbourhood Teams (INT). Each of these INTs are best equipped to understand and drive the changes that our communities want and need by bringing together professionals across Health & Social Care and Voluntary, Community and Social Enterprise.

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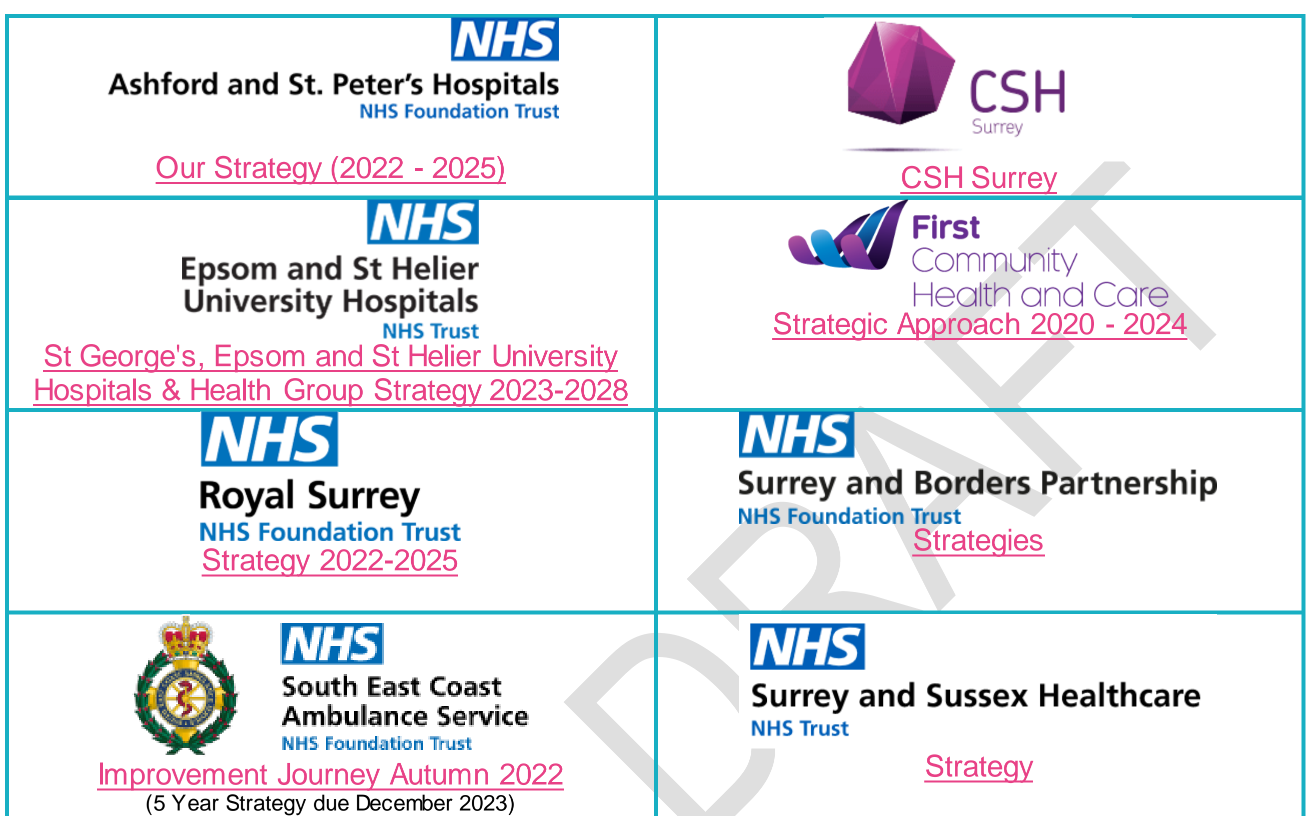
Partner Strategies

Surrey Heartlands Provider Partners each have strategies which support delivery of their organisational, NHS and ICS objectives to meet the physical and mental health needs of our populations. You can read more about these on our providers' websites.



NHS Ashford and St. Peter's Hospitals NHS Foundation Trust Our Strategy (2022 - 2025)	CSH Surrey CSH Surrey
NHS Epsom and St Helier University Hospitals NHS Trust St George's, Epsom and St Helier University Hospitals & Health Group Strategy 2023-2028	First Community Health and Care Strategic Approach 2020 - 2024
NHS Royal Surrey NHS Foundation Trust Strategy 2022-2025	NHS Surrey and Borders Partnership NHS Foundation Trust Strategies
NHS South East Coast Ambulance Service NHS Foundation Trust Improvement Journey Autumn 2022 (5 Year Strategy due December 2023)	NHS Surrey and Sussex Healthcare NHS Trust Strategy

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Provider Collaboratives

The Surrey Heartlands Trust Provider Collaborative (TPC) is where the three acute trusts and the mental health trust work collaboratively as the experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability. Each Trust will retain its own identity, support development and delivery of Place strategies, and within the collaborative lead on specific clinical services to optimise patient outcomes through delivery of operational excellence and value for money.

The TPC is expected to be formally in place from August 2023, and will focus on agreed priorities which need to be addressed as a provider system rather than at organisational level. The agreed priorities for 2023/24 are the elective centre, stroke, cancer, maternity and neonatal, and paediatric services; as well as a focus on mental health and acute partnership to ensure that people who present with acute mental illness receive the appropriate clinical input in a timely way and in an appropriate environment. The TPC will continue to focus on elective recovery and addressing unwarranted clinical variation.

The TPC will focus on transformation that needs to be undertaken across the providers at scale, while continuing to play a key role in working with colleagues at Place to deliver the agreed local priorities that recognise that neighbourhood needs are unique and varied.

Programmes will be structured with Multi-Professional Clinical Leads to ensure there is coproduction of the underpinning principles to innovate, and to optimise opportunities to deliver at scale where this provides clear benefits. We have already seen the Virtual Ward Programme benefitting from the collective design and agreed underpinning principles to minimise inequalities emerging from the

Programme. This approach extends across Community services and Primary Care and Patient Carers for future Virtual Care.

Social Care

Social Care in Surrey is delivered through a number of different routes. There are statutory services provided directly by Local Authorities, provision supplied by the VCSE, independent Care Providers and of course, the vast amount of care provided by unpaid carers which is often unseen and unrecognised. Social care, unlike health care, is means tested and this creates an additional layer of complexity in Surrey given that approximately two thirds of Surrey residents fund their own care. In many instances, those who self-fund their care will need to arrange it for themselves, often navigating a complex system at a point of crisis.

People at the Heart of Care set out the 10 year vision for adult social care. From this we have shaped three point vision for Surrey, so that our people:

1. Are informed and able, or have the support, to make decisions about their lives
2. Are enabled to be active, independent and have good wellbeing
3. Are connected to their communities

Our social care strategic priorities reflect our commitment to a modern service promoting people's independence, wellbeing and fulfilling lives.

- Developing an innovative, high-quality prevention approach, underpinned by an accessible digital offer for those residents who are able to self-serve to access information and advice on demand and personalised support for those who need it.
- Transforming Surrey's reablement offer to support all people, from the community and following hospital discharge, who would benefit from personalised support to achieve their goals and to gain or re-gain skills, confidence and independence.
- Improving mental health outcomes to maximise independence for Surrey's people through better early intervention, prevention, targeted and long-term support.
- Delivering with partners modern, technology-enabled homes and accommodation models with the right care and support to enable people to live as independently as possible.
- Working together as an effective and financially sustainable system, with place-based partners and residents to co-produce services, to deliver good outcomes for people, support them to access health and social care at the right time and in the right place.
- Working in partnership to improve outcomes for young people in transition to adulthood to maximise their independence and live their best life.
- Enhancing our commitment to consistent strengths-based approaches to prevent, reduce and delay reliance on, and demand for, long-term care.
- Creating the environment for staff to develop, progress their careers and thrive in a respectful, inclusive workplace with a supportive culture.

You can read more about our social care delivery plans in the 'Fact File' on our website.

Carers

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or addiction and cannot cope without their support. The care they give is unpaid.

Surrey Heartlands will be a place where carers are recognised, valued and supported as pivotal to the ambition of the system, both in their caring role and as an individual. We want to do everything we can to enable carers to live well. It is crucially important that carers are identified at the earliest opportunity. Carers will be respected as partners in care, will have a strong voice that influences improvement, and will be able to access responsive support they need, when they need it, and in the way that works best for them. This support will be available equally to all carers.

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Our vision is that young carers feel supported and confident to say that they are a young carer. They are identified, recognised, valued, and supported, and protected from providing inappropriate care, to achieve their full potential, and to have equitable access to the same opportunities as their peers. They have a strong voice that results in services that work for them, and we hear their voice when the responsibility of caring is not their choice. Across the system, staff will have the tools, skills and know ledge to increase identification of young carers, enable young carers to self-identify and provide the right support to young carers and their families. We will develop an 'All-Age Carers Strategy' aiming for publication by the end of 2024/25.

Our work includes the following priorities for **young people**:

- Increased awareness visibility and support of young carers in education, health and social care
  - Training for improved identification of young carers and a whole family approach
  - Improved transfer of information
  - Consider young carers in any system change
- Staff have a good understanding of young carer's rights and young carers and their families have the tools they need to advocate for themselves.
  - Ensuring that young carers and their families feel able to request a young carer's assessment and staff have the skills to put them in place
  - Championing young carer's rights
  - Transition to adult services
- Young carers safeguarding needs are identified and supported
  - Appropriate referrals made for early help to avoid any escalation and preventing the threshold of 'significant harm' being reached

Our work includes the following priorities for **adults**:

- Place based carer action groups
- Personalisation (Social Prescribing and Carers Personal Health Budgets), Carer Passports
- Hospital Discharge and Community Support Guidance Hospital discharge and community support guidance
- Inclusion of carers in the co-design of virtual wards in Heartlands and the implementation of the wards at Place. Surrey Independent Carers Lead appointed to the Virtual Ward Programme Board.

You can read more about our delivery plans in our adult carers and young carers strategies and find out helpful information on our Carers page on the Surrey Heartlands website.

The following chapters describe how our strategic priorities will be delivered by the Integrated Care Board (ICB) and its partners.

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1. Prevention and Keeping People Well

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

Our Health and Wellbeing Strategy based on our JSNA focuses on three linked priorities:

- Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being
- Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being
- Supporting people to reach their potential by addressing the wider determinants of health

Most people in Surrey lead healthier lives than the average UK citizen. However, this strong average performance often masks areas of underperformance, inequality or where additional focus is required. We will focus on delivering reduced **health inequalities** for our priority populations – those with the poorest health outcomes - through the CORE20PLUS5 programmes for adults and children.

You can access quarterly highlight reports which provide an overview of the progress of local shared projects supporting the delivery of the Health and Well-being Strategy on the Healthy Surrey website.

1.1. Supporting people to lead healthy by preventing physical ill health and promoting physical well-being

We are participating as one of only fifteen areas in the country operating a National Changing Futures Programme to support the most vulnerable individuals in our communities with **multiple disadvantage** and help them achieve their goals. The Changing Futures Programme in Surrey explores gaps in care, unwarranted variation and disparities in health and care outcomes for this population and challenges opportunities where the system could be effective in improving the outcomes.

Surrey's Changing Futures Programme has introduced Bridge the Gap Trauma Informed Assertive Outreach alliance of homeless, mental health and domestic abuse providers to support optimal outcomes for people with multiple disadvantages. The alliance is a group of third-sector providers delivering a specialist, relational model of trauma-informed outreach for adults with multiple disadvantage, supported by clinical psychologists who are trauma specialists. A full evaluation of the Changing Futures programme has been commissioned for 2023/24. Resolution of these issues offer not only the prospect of reducing offending and reoffending rates, but significant societal benefits and a reduction in costs for the health service, social care, police, and criminal justice systems.

Another example, is our system approach to physical activity, including improving use of green spaces, transport initiatives, and healthy planning to enhance the preventative aspects of wellbeing. Since the development of our Long Term Plan, the number of adults classed as inactive in Surrey is the lowest ever, at 19.5%[1] however over 50% of young people are still not meeting Chief Medical

[1] people who do less than 30 minutes of activity a week (www.activesurrey.com). England average 21.4% (18/19).

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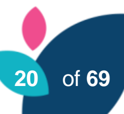

Officers' physical activity guidelines. We will continue to develop the range of support such as nutrition, physical activities and children's healthy weight on our Healthy Surrey website.

Prevention of ill health includes screening and **Health Protection** activities, which encompass a set of public health activities protecting individuals, groups and populations from infectious disease such as childhood vaccines for preventable diseases and seasonal influenza, incidents and outbreaks - managed by our system Emergency Preparedness processes, all help people to stay well for longer.

Our ambition is that everyone in later life can experience good physical health and emotional wellbeing, have a sense of meaning and purpose, social connectedness and better resilience. We will achieve healthy aging and care through improving our integrated health and care services to provide seamless treatment and support when needed, promoting good health and wellbeing, early intervention and prevention, in a way patients can control and plan in our towns and through neighbourhood teams.

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by 19.6%. As this population grows, there is will be a rise in the number of people with multimorbidity, such as dementia and diabetes alongside frailty which is associated with increasing age. We know that being active can increase the amount of time that people can stay independent and healthy.

As we age, it is common to have a growing number of health issues. Over time, this can affect our ability to bounce back after an illness or other stressful events, as well as our ability to live independently or keep in touch with family and friends.

Our Living Well in Later Life Strategy sets out the support for people in Surrey. It is shaped from the views of hundreds of residents, carers, staff and care providers. This is our plan for how we will help residents to have more choice and control over the care and support they need, when and where they need it. We will change how we design and buy services and work with partners to make these changes.

CASE STUDY

Live Longer Better pilot through Active Surrey in Elmbridge is focused on helping people stay healthy, happy and independent for as long as possible. It's mission is to change the culture surrounding ageing, replacing the concept of care with the concept of enablement. It includes improving physical ability and resilience, preventing and coping with disease and understanding and changing how people think about ageing.

By 2028 our population will benefit from:

- People have a healthy weight and are active.
- Substance misuse is low (drugs/alcohol/smoking).
- The needs of those experiencing multiple disadvantages are met.
- Serious conditions and diseases are prevented.
- People are supported to live well independently for as long as possible.

1.2. Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being

This priority is about enabling the emotional wellbeing of our citizens by focusing on preventing poor mental health and supporting those with mental health needs, so people have access to early, appropriate support to prevent further escalation of need, including parents and care givers.

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We have a strong and growing **social prescribing** network and expanded **green social prescribing** initiatives across our Places which are a collaboration between health, social care, district & borough councils and a range of voluntary sector organisations in our Neighbourhood Teams. These provide proactive, personalised support such as healthy lifestyles and physical activity, debt and benefits services and mental health & emotional wellbeing.

CASE STUDY

Social Prescribing in Guildford & Waverley Neighbourhoods

Mark is a veteran with Post Traumatic Stress Disorder (PTSD), depression, anxiety and chronic pain from a back injury. Mark receives some practical support from adult social care. Mark wanted to have more interaction with other people as he was limited to small amounts of employment due to his injury. Through social prescribing Mark was put in touch with Welcome Buddies and Welcome to Volunteering (supported access to a volunteer placement). Although Mark was referred as a client, he was more interested in becoming a volunteer buddy to support others. He is now working towards becoming a buddy and mentor for people with mental health issues as part of the Welcome Buddies project.

By 2028 our population will benefit from:

- Adult, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources.
- The emotional wellbeing of parents and caregivers, babies and children is supported.
- Isolation is prevented and those that feel isolated are supported.
- Environments and communities in which people live, work and learn build good mental health.

Our NHS delivery priorities to achieve these successes are described in chapter 2 - Delivering Care Differently. You can read more about our work to improve health and wellbeing through social prescribing on the Surrey County Council website.

1.3. Supporting people to reach their potential by addressing the wider determinants of health

We will support our citizens to reach their potential by helping them to develop the skills needed to succeed in life and flourish in a safe community. This is not only about making sure people's basic needs are met but also about skills development, training and employment, involvement in life-long learning and in their own communities and considering the impact of community safety and the built/natural environment on health.

We aim to improve the perception of disability and increase expectations for everyone. Our Physical Disability and Sensory Impairment Strategy aims to remove barriers and support people with disabilities to become well informed and expert in their own needs and better able to exercise their rights, choices and life opportunities.

By 2028 our population will benefit from:

- People's basic needs are met (including food security, poverty, housing strategy).
- Children, young people and adults are empowered in their communities.
- People access training and employment opportunities within a sustainable economy.
- People are safe and feel safe (community safety including domestic abuse, safeguarding)
- The benefits of healthy environments for people are valued and maximised (including through transport/land use planning).

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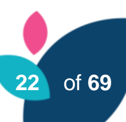

2. Delivering Care Differently

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

Our populations have told us they want a model of care which is responsive to their needs and puts them at the centre of decision making. To enable this, we have determined two main aims as we transform how we deliver care:

- 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.

We are putting delivery of joined up health and care services at the heart of our approach – integrated care - enabling 'Making Every Contact Count' to provide proactive and personalised care through our developing Place and Neighbourhood teams.

We will enable people to easily access high quality care and focus on support where it's most needed to access care through our commitment to improving the navigation and information relating to health and care services ensuring:

- Proactive access, joined up health and care support
- Digitally advanced services
- Nobody is left behind

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We need to manage rising demand, on behalf of patients and staff, at the same time as recovering our system post-pandemic, reducing waiting times and transforming how we provide care and support people in their communities. We are moving away from reactive treatment of illness to proactive and preventative care promoting health and wellness. We aim to ensure every person can access care easily, efficiently and receive the help and support of their choosing and when people want personalised care, receive it through multi-disciplinary teams and care coordination.

2.1. Making it easier for people to access the care that they need

We will move patients safely and efficiently through our clinical pathways, delivering high quality care based on the 'Get it Right First Time' principles.

This chapter focuses on improved access - including service navigation - and integrated care pathway developments, ensuring healthcare works effectively when needed and movement through health and care services known as 'system flow' improves.

We are proud to have showcased how we are enhancing access to primary care and joining up services for patients to Amanda Pritchard, Chief Executive of the NHS in March 2023.

"The team here are showing the benefits that can come through embracing the power of technology, making best use of the skills of a wide group of clinicians and other professionals, and forging strong links with communities and other services – and it is exactly these benefits which the NHS is working to ensure people across the country can enjoy."

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We will deliver this integrated system working through our collaborative organisation partnerships focusing around the needs of the patient. This is not just about transforming how services are delivered on the front line, it's also about realigning our functions and re-imagining how they can enable our teams to work together.

Primary Care

Good primary care is the foundation of an effective health system for patients. When working well, it supports the early identification of serious illnesses and the management of chronic conditions, while also helping people to live healthier lives. To achieve this, two defined areas aligned to the Fuller Stocktake and the delivery plan for recovering access to primary care, have been identified:

- **Personalised Care for the who need it**: delivering care from a named health or care professional (using all disciplines in Health & Care)
- **Streamlined Access:** Expanding MDTs and providing flexibility to tailor services to local demands. Optimising data and technology to integrate siloed same day urgent care services.

Access challenges are being caused by an increased demand for services - both volume and complexity - combined with ongoing workforce pressures and reduced numbers of GP.

Our system has a clear support offer to general practice which aims to provide insight in addition to radically transforming general practice and wider Primary Care services (Figure 5). We strongly believe that patients should always be able to receive the same, or an equivalent service, however they access their GP practice - be that digitally, by telephone or by walking into the surgery.

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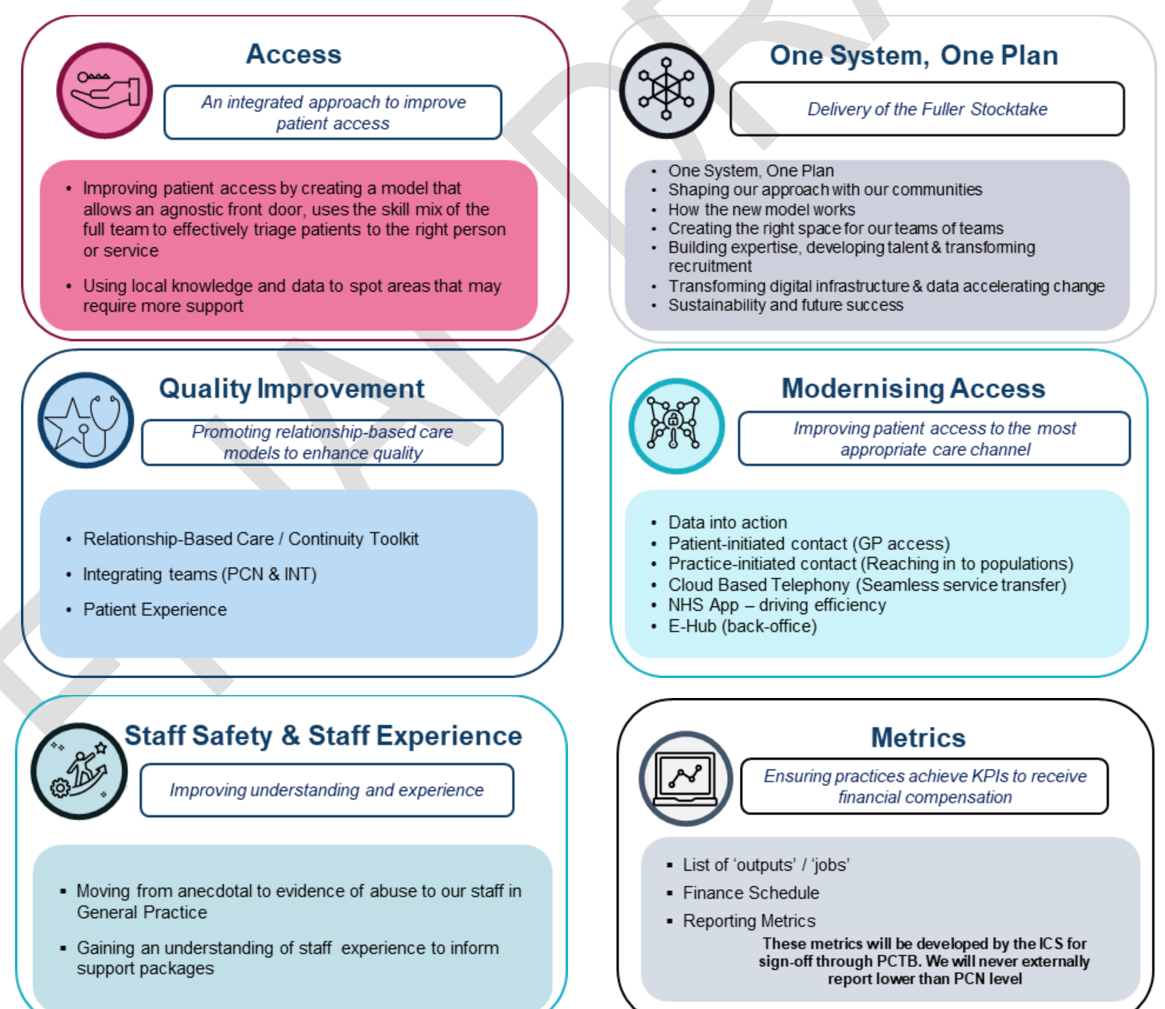

Figure 5 – General Practice Development Toolkit key components to transform the models of care and streamline the patient journey

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Improving Patient Access
We have designed our patient-initiated and practice-initiated models to find the most efficient and effective way for patients to access and be contacted by General Practice (Figure 6). The models will incorporate technologies such as advanced telephony - cloud based systems with clinical system integration – and the NHS APP to ensure our population is able to access a wide range of services and support when they need.

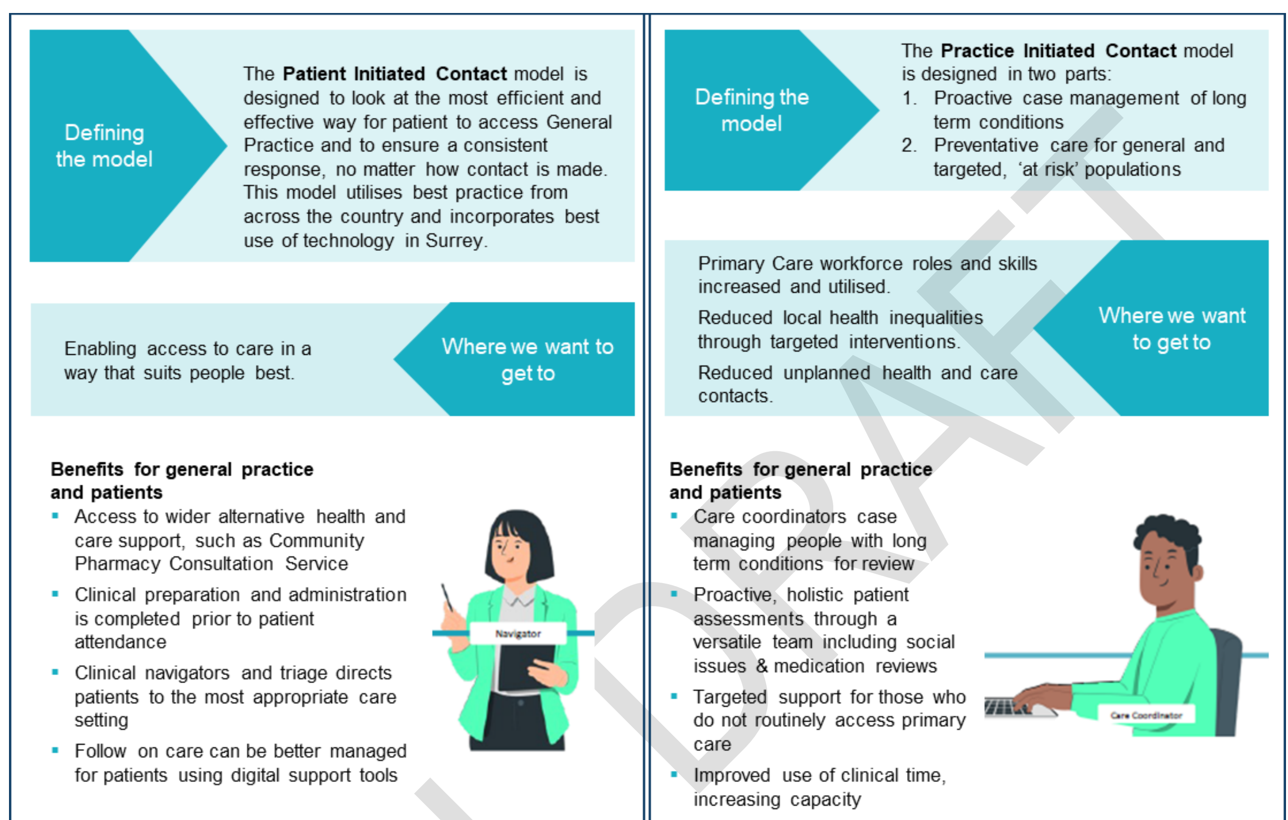

Figure 6 – patient and practice initiated contact models

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CASE STUDY

Primary Care Networks – **Growing Health Together** works across East Surrey has seen primary and community health care workers, social prescribers, the county council, borough and district councils, VCSE groups and others collaborate - getting alongside communities to support, enable and promote citizen-led action and projects that create social connections and improve health and wellbeing - this includes, for example, community gardens, arts and music events and peer support groups.

Through the Community and Mental Health Transformation (CMHT) programme we are implementing **General Practice Integrated Mental Health Services** (GPIMHS). We are embedding teams into primary care networks through the NHS England early implementer CMHT funding, with full coverage achieved by 202023/24, across Surrey Heartlands.

Within each primary care network an integrated multi-agency GPIMHS team is deployed, including representation from health, social care, the third sector and people with lived experience of mental health needs. As well as supporting people to stay well and out of hospital, the programme supports people currently in secondary care mental health services who are stable and would be well placed to alternatively receive recovery focused and integrated mental health care services in primary care, with seamless 'easy in' and 'easy out' as required, and with a potential shared care arrangement.

Our key delivery priorities to achieve our aims include:

- **Continuity of Care** – Reducing fragmentation and promoting joint up pathways including expanding MDTs in community pathways
- **Patient Experience** – Gathering regular feedback to promote a proactive approach to the improvement in the ease of access to general practice
- **Professional Integration** - aligning teams between PCNs and INTs

Community Pharmacy, Optometry & Dentistry

Giving ICSs responsibility for direct commissioning is a key enabler for integrating care and improving population health in line with the NHS Long Term Plan. It provides the flexibility to join up key pathways of care, leading to better outcomes and experience for patients, and less bureaucracy and duplication for clinicians and other staff. Therefore, as part of empowering local decision making, NHS England (NHSE) set out the intention to delegate commissioning functions of Community Pharmacy, Optometry and Dentistry (POD) to all ICSs by April 2023; Surrey Heartlands became an early adopter and transitioned the services in July 2022.

By co-designing additional support and services we will better deliver the national contract, expedite recovery and aid retention issues in our dental practices and professionals (Figure 7).

11

Community Pharmacy

Community Pharmacists will provide an expanding range and supply of medicines optimisation services into local care pathways.

BY 2028 PATIENTS WILL BENEFIT FROM:

- Community pharmacies being the preferred NHS treatment location for appropriate minor health conditions
- Timely, convenient access to care, medicines and advice
- Community pharmacists becoming integral to helping people stay healthy & identifying those at risk of disease

Optometry

NHS funded sight tests for eligible patients will be managed and procured by local teams who understand their community and equality needs for general ophthalmic services.

BY 2028 PATIENTS WILL BENEFIT FROM:

- Special School Eye Care service
- Homeless and Asylum Seekers access
- Access to sight tests for adults with learning disabilities

Dentistry

NHS funded services including specialist, community and out of hours managed by local teams who understand the community and equity needs.

BY 2028 PATIENTS WILL BENEFIT FROM:

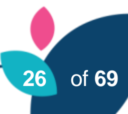
- Improved general access through primary care integration and urgent access for those without a regular dentist
- Reduced oral surgery hospital waits for treatment
- Enhanced access in hospital for patients with special needs and paediatrics

Figure 7- Community Pharmacy, Optometry and Dentistry transformation focus

The Surrey Training Hub exists to develop, support, retain, and attract the primary care workforce through education and training opportunities.

By 2028 our population will benefit from**:**

- Improved telephony and triage to helping practices manage demand;
- Enhanced booking and triage capabilities to local walk-in sites;
- Local service provision to meet identified challenges in our neighbourhoods;
- Expanded primary care offer at our walk-in sites, including same day emergency care pathways;
- Freeing up GP appointments so that people who need to receive GP advice are able to see their GP more quickly.
- Integrated urgent care pathways such as virtual wards as part of care pathways.



Community Care

We know that integrated care teams in the community reduce the likelihood of emergency care needs, enabling people to live in as good health and where appropriate, as independent as possible. Our Community Transformation comprises of 5 workstreams:

1. **Urgent community Response** (UCR) aims to expand and improve the Reablement, Intermediate, Virtual Ward capacity and ensure a two hour urgent community response service is available 7 days a week.
2. **Community Health Services** workstream focuses on pathway redesign and improvement for community based services and initiatives including Long Covid, Population Health Management, Carers and Children and Young People community services.
3. **Integrated Community Pathways** focusses more on safe and effective discharge using 'discharge to assess' models, trusted assessors, Personal Health Budgets (PHB) and expanding multidisciplinary teams in the community.
4. **Care homes & Domiciliary Care** aims to further integrated Health and Social care, linking PCNs, Care homes and the Enhanced Health in Care Homes model.
5. **Prevention and independent living** includes the vaccination programmes, further digital tools and services such as virtual wards and 'Making Every Contact Count'.

Our proactive and preventative care is delivered in many ways across our communities, such as offering **blood pressure and atrial fibrillation** screening to eligible patients following Covid19 vaccination. Clinicians with a special interest, such as in frail elderly people, lead our **complex care** function, acting as the link between the integrated neighbourhood team and complex care function in each Place to co-ordinate integrated decision making and care. INTs will identify patients through clinical judgement, conversations with patients, and risk stratification enabled by population data. We will continue support those through NHS Continuing Healthcare or **Continuing Care** Packages for children (where eligible) to enable people with long term complex health needs, receive care outside of hospital such as their home or care home to aid improvement in the quality of life.

We will better support people by having in place a community-based **falls response** service in all systems for people who have fallen at home including care homes and providing **additional support for care homes** through reducing unwarranted variation in ambulance conveyance rates.

We will **maximise the use of virtual wards** as an alternative to admission or earlier safe and supported discharge seven days a week, 8am to 8 pm. By supporting acute capacity management, virtual wards add value in making our services more sustainable and provide care closer to home. Our model brings together primary care, secondary care, and community services to support patients who would otherwise be in hospital. We are expanding our step-down capacity and we've developed a step-up model that will operate at place level and evaluating the establishment of an Acute Respiratory Infection (ARI) hub to support same-day assessment.

Our Better Care Fund (BCF) supports people to live healthy, independent and dignified lives by joining up health, social care and housing services. Surrey County Council, Surrey Heartlands Integrated Care Board and Frimley Integrated Care Board agree a joint BCF plan for Surrey which is owned by the Surrey Health and Wellbeing Board (HWB). It is aligned with the Surrey HWB strategy delivery and governed to tackle pressures faced across the health and social care system and drive better outcomes for people.

The BCF programme underpins key priorities in the NHS Long Term Plan, joining up services in the community - such as support for unpaid carers, housing support and public health and supporting 'Next steps to put People at the Heart of Care'. Our BCF programmes will begin to support prevention programmes and continue to facilitate the smooth transition of people out of hospital, reduce the chances of re-admission and support people to avoid long term residential care by acting on the plan to recover urgent and emergency services.

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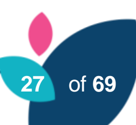

We are working closely with colleagues across other parts of Surrey, including the Frimley Integrated Care System and Southwest London Integrated Care System, to ensure our ambitions for high quality, compassionate, person centred, co-ordinated **palliative and end of life care** to meet people's wishes and choices (dying well), are aligned across the whole county. Our Palliative and End of Life Care strategy is being led at a local level by our Place partnerships. You can read more about the improvement ambitions and support information on the Surrey Heartlands website.

By 2028 our population will benefit from:

- A workforce that works around the child from buildings local to families and within communities
- An increase in personalised care provided by multi-agency, multidisciplinary teams with care coordinators, enabling patients to see the same clinicians or teams
- Targeted support where there is clear inequality in terms of life expectancy, immunisation, screening in populations who aren't routine health seekers
- Relevant services are part of Surrey Family Hubs and Frailty Hubs support adults and children close to home
- Digitally shared care records to support individuals get the care and support they need
- Support for all care home residents requiring frailty and enhanced health care
- Seamless urgent community response and virtual wards provision for people with escalating health and care needs, ensuring access to timely support and early interventions in their place of residence
- Increased opportunities to access immunisations and vaccinations for adults and children

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Urgent Care

Our **urgent and emergency care** system is challenged across both our local practices and the wider care system. Unless we work across the traditional boundaries of primary and urgent care as one system using one plan, the relentless pressures on our health and care system that have become commonplace will not go away.

Central to our approach, we are developing effective, resilient, neighbourhood-based same-day access to urgent care that can serve as an easily accessible first point of contact for patients with routine issues. This sits as part of our integrated urgent care pathway, which ensures clarity for patients and referring clinicians (Figure 8).

Our ambition is to improve access to same day urgent care for those who need it, free up capacity to enable continuity of care and test and learn to shape new approaches that work locally. There will be separate emergency and urgent care services, which are clearly defined purpose, appropriate access and care provided for adults and children.

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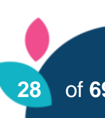

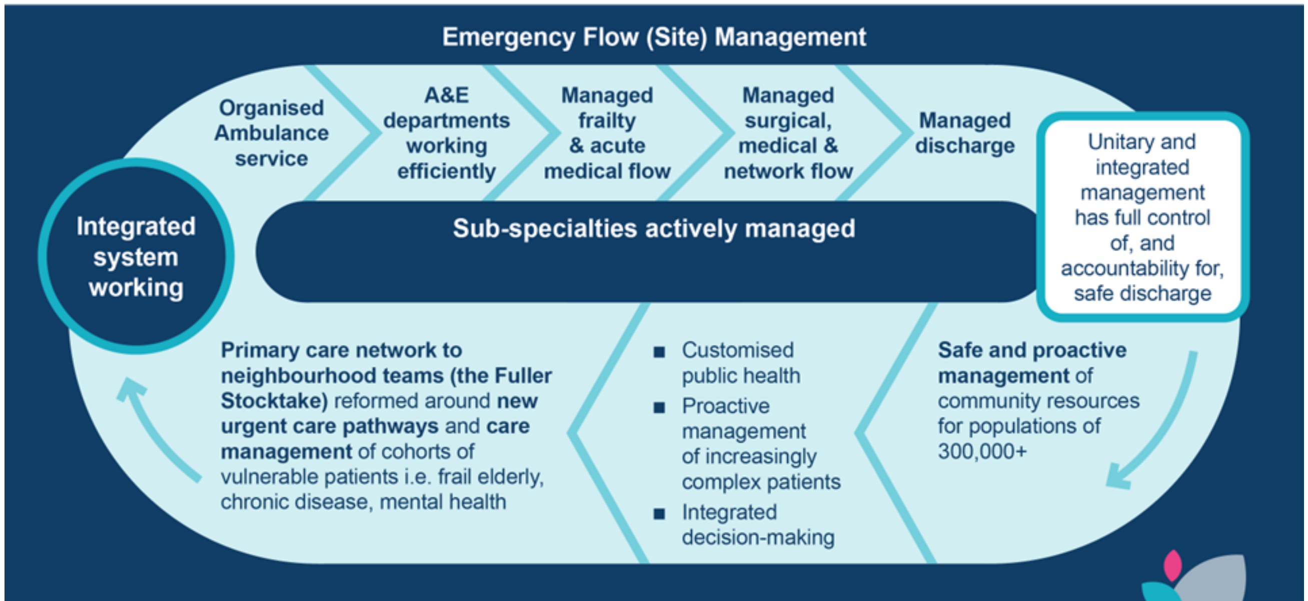

Figure 8 – Integrated system working

We are developing new proactive models that work to allow same day urgent care access directly to our local communities across digital, innovation and hub models. These include:

- **Enhanced access hubs** – same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends
- **Urgent community response** - for our more complex and frail patients we will provide a multidisciplinary rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital
- **Urgent children and young people response** - many children and young people attend A&E with minor complaints that could have been treated in the community. We are exploring ways in which children will be treated closer to home in a more appropriate settings such as virtual wards. This includes some elements of care that have historically been given in hospital
- **Community diagnostic hubs** – working across Place we have developed models of diagnostics that are placed within local communities, including 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
- **Care homes** – we have implemented a multidisciplinary approach to the management of care for these residents, particularly those who are more complex requiring extra support to avoid hospital admission
- **Frailty models of care** - we have developed key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely
- **Anticipatory care models** – using our new digital risk stratification we can better target those most at risk of admission and attendance into the urgent care system
- **Triage improvements in referral processes** are proving effective in enabling the 'right care, in the right place' and we are now looking to extend these models across practices.

CASE STUDY

Surrey Downs Urgent Care Coordination Centre - is a single point of access for all referrals (including from health and social care colleagues, 111 and self-referral). The single point of access will allocate referrals to the appropriate team within the place-based urgent care pathway - whether

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it is urgent community response, virtual ward, Homefirst+ or primary care network hubs. It aims to streamline and support greater clarity in navigating the system for all and can provide care coordination as patients move through the pathway ensuring continuity of care.

Same Day Emergency Care (SDEC) is a service that provides emergency care to people without the need for an admission to hospital and can provide direct referral into mental health services, dentistry, community pharmacy and services such as ophthalmology. We will ensure:

- SDEC operates 7 days a week for 12 hours daily.
- Enhanced diagnostic access and referral routes with an increase in the number of Advanced Practitioners.
- Surrey Heartlands meets the core service provision as per Long Term Plan, including community child and adolescent mental health services and 24 hour a day crisis teams.

Our **NHS 111 service** supports people who need urgent not a life-threatening emergency care. It provides advice and treatment if your GP practice is closed or if people are injured or ill and are unsure what to do. Surrey Heartlands in line with national ambitions, is continuing to develop this service to make it easier for people to access the care that they need and support emergency departments to work more effectively. This includes dedicated paediatric advice and guidance for families to support decision making around care options. You can find out more about how our service works on our website.

Ambulance

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Our ambulance services are under extreme pressure resulting in slower call response times and fewer resources available. We know that handover delays – the time from arrival to transfer to a clinician at hospital – are not the only cause of slower ambulance response times. Our ambulance trust South East Coast Ambulance (SECAmb), like many across the country, has experienced increases in sickness and other staff absence, along with the complexity of ambulance crews' work increase meaning each incident is taking longer.

Surrey Heartlands ICS and SECAmb are committed to getting ambulances to patients quicker and in turn support recovery of patient flow. During 202023/24 we will improve ambulance response times for Category 2 incidents to 30 minutes on average, with further improvement in 2024/25 towards pre-pandemic levels.

SECAmb has established specific strategic objectives to achieve our collective aims; Quality Improvement, Responsive Care, People & Culture, and Sustainability & Partnerships. These will provide safe, effective, and timely response times for patients through the implementation of smarter and safer approaches to patient care and to become a sustainable provider by optimising referral pathways and avoiding inappropriate conveyance to emergency departments.

The Trust Board priorities and aspirations align with the Integrated Care System's Joint Forward Plan and demonstrate the Trust's commitment to improving patient outcomes, delivering high-quality and responsive care, developing sustainable healthcare provision, building a culture of continuous improvement, and promoting a positive and inclusive culture. The Trust aims to become a leader in the UEC arena, providing exceptional care to its patients and supporting its staff in delivering this, working as a key partner is each the four integrated care systems to which it relates.

Emergency Care

Surrey Heartlands ICS has experienced exceptional pressures throughout 2022 and into 2023. Unlike previous years, this has not been wholly created by increases in demand, increased ambulance conveyances and NHS 111, but exacerbated by high number of patients who no longer need to reside in hospital severely constricting patient flow into and out of hospital.

Our primary focus is delivering the NHS recovering urgent and emergency services two year plan to regain improved waiting times and patient experience. The integrated system working described earlier will enable us to support people access the care they need and alleviate continuation of care delays to recover patient flow . We are committed to the ambition to improve the percentage of

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patients being admitted, transferred or discharged within four hours by March 2024 to the national 76% target, with further improvement in 2024/25.

Managed Discharge

We know that long stays in hospital through delayed discharges, are not good for patients and significantly impacts how hospitals are able to provide services. We will focus on improving discharge processes – sometimes known as 'flow'- between hospitals, community services, local authorities and social care to improve health and care outcomes plus patient experience.

Surrey Heartlands will deliver health and care discharge services seven days a week for people ready to leave an acute hospital bed. Surrey Heartlands will continue to build on personalised health and care initiatives that focus on people leaving the hospital, including interim care support packages coordinated across health, social care and voluntary sector partners. Getting discharge planning right is a crucial component of our process for managing surges in demand.

The NHS Delivery plan for recovering urgent and emergency care services encourages us to centre our improvement work on joint discharge processes, intermediate care and social care services. We will focus our efforts on embedding discharge planning at the point of admission with an estimated discharge date and identifying those with complex discharge needs by working with families and carers. We will use our 'Discharge to (Recover and) Assess' (D2A) to facilitate care closer to people's homes, with increased health and care agency coordination for intermediate care and domiciliary care, and supported by the Better Care Fund.

CASE STUDY

A pilot for in-reach community nursing within the **Royal Surrey County Hospital** was launched in January 2022. The adult community discharge senior nurses work to review all Guildford and Waverley community nursing caseload admissions to the hospital prior to their discharge home. The nurses are made aware of any patients on the district nursing caseload attending A&E and assist with preventing unnecessary admissions.

In the first six weeks community nurses received 165 referrals, promoting self-care in 21 patients, facilitating four early discharges and referring five frequent attenders who were previously unknown to the community matrons, in the hope of preventing avoidable admissions. The self-care instruction to insulin dependent patients alone avoided costs of estimated £93,447 per year. Feedback from staff within the hospital Trust was extremely positive and the decision was taken to provide Better Care Funding to expand and extend these roles.

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By 2028 our population will benefit from:

- Providing clear relevant information to ensure patients can access alternative services for urgent same day care.
- Providing access to online resources 24/7, in a variety of formats, so that support can be given more quickly for many conditions.
- Neighbouring partners working together for walk-in sites booked appointments and Same Day Emergency Care (SDEC) pathways.
- Providing greater opportunity for care and support to be tailored to the individual's own support network and community.
- Urgent and emergency care services are consistently rated as good or outstanding.
- Our urgent and emergency care system is attractive to staff to work in.
- Linking care records, with consent, so that the person is able to 'tell their story once'.
- Providing more direct appointments with many local services, considerably reducing wait times.
- Ensuring that the Emergency Departments are better able to meet the needs of people who require emergency care due to suffering a life-threatening health event.
- Reducing wait times within the Emergency Departments; and increasing timely discharge from hospital.

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Maternity and Neonatal Care

The best start in life begins well before birth. The NHS Long Term Plan national set the ambition to halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. Within Surrey Heartlands we aim to ensure patient safety and to go further to achieve sustainable, high-quality physical and mental health care for women, birthing people and babies that meets the wide range of needs in our communities.

This means increasing choice, personalisation and continuity of carer, listening to women and birthing people, improving access to maternity and perinatal mental health services and improving uptake of prevention activities. Our local maternity and neonatal system seeks to provide women, birthing people and their partners with a positive, supportive experience from conception through to caring for their baby after the birth.

We know from the Independent Reviews of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2020 and 2022) and Maternity and Neonatal Services in East Kent: 'Reading the signals' we need to develop multi-professional training, recruitment and retention. We are proactively focusing on safety, positive cultures, and future workforce concerns within our Maternity Services. We will align our work with NHS England's three year delivery plan for maternity and neonatal services, including achieving the national ambitions by 2025.

We will prioritise improving and co-designing maternity and neonatal services in collaboration with pregnant women and birthing people through our local Maternity Voice Partnership (MVP), to ensure maternity equity and meet the needs of communities. Our key provision priorities include personalised care, continuity of carer and establishment of community hubs, improved postnatal care and appropriate bereavement care services for women who suffer pregnancy loss.

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To improve outcomes for women, birthing people and babies, we have a number of priorities including:

- To halve the rates of stillbirths, neonatal mortality, maternal mortality and brain injury by 2025. Our collaborative Maternal Medicine Network with Southwest London LMNS will improve outcomes for women and consequently babies and referral criteria will reflect the increased vulnerability of women from ethnic minorities and those who are socially deprived.
- Addressing health inequalities - Our 5-year perinatal equity strategy.
- Physical health - to work with Southwest London Maternal Medicine Network to develop pathways for maternal medicine and we will scope services for pelvic health following birth.
- Emotional wellbeing: Perinatal Mental Health - ensuring that every woman:
  - Has access to services to during the antenatal period for 2 years after birth.
  - Is able to access quality perinatal mental health care and treatment at the right time, at the right level and at the right location
- Public health – We are working on pathways for smoking cessation during pregnancy in collaboration with Public Health. We also have public Health campaigns such as Ready for Pregnancy and Ready for Parenthood.

CASE STUDY

The Maternity and Neonatal Voices Partnership (MVP) is a national initiative that brings women, birthing people and families together with NHS staff and other stakeholders in an equal partnership to coproduce improvements to local maternity services. NHS Surrey Heartlands has four MVPs; one for each of our maternity provider trusts. The MVPs are chaired by a team of local mums with lived experiences within each trust. Our MVPs will continue to lead on gathering feedback from women and families in a variety of ways (from 'Walking the Patch' at the maternity unit, to visiting toddler and community groups), and work with staff to keep women and families' voices at the heart of maternity and neonatal improvements and developments.

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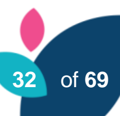

MVP activity includes building relationships with local faith groups, food banks and charities, attending and presenting at Trust quality & safety meetings, co-producing bereavement pathways and literature, social media engagement with the public, contributing to strategies, and co-producing information and communications literature.

By 2028 our population will benefit from:

- Services co- designed with pregnant women and birthing people.
- A reduced rate of still births, neonatal and maternal mortality and morbidity.
- Feedback from women and birthing people demonstrating that they are listened to, have a choice and are the key decision maker for their care.
- Pregnant women and birthing people offered continuity of carer.
- Whenever possible, care closer to home.

Children and Young People

High quality services for children and young people are essential to improving whole of life health outcomes and reducing health inequalities. Poor health outcomes can become embedded early in childhood, so children and young people access a wide range of services during this life phase affords many opportunities to tackle this and make improvements. We are focusing on managing children effectively in primary care or community settings to improve the quality of care for acute and longer term illness.

The NHS Long term plan sets out key aspirations which consider the diverse and complex needs of children. The focus includes improving the quality of care for children with long term conditions such as asthma, epilepsy, diabetes and, more recently, long covid; right sizing paediatric critical care and surgical services to meet the changing needs of patients, ensuring that children and young people access high quality care as close to home as possible and selectively moving to a '0-25 years' service which will improve children's experience of care, outcomes and continuity of care.

The Best Start for Surrey Strategy has set the transformation ambitions for pregnancy and early childhood (up to age 5) over five years (2022 – 2027), with a focus on our collaborative transformation plans as an ICS. The delivery of this strategy will ensure that every child and family in Surrey has the best start in life.

CASE STUDY

Surrey and Borders Partnership NHS Foundation Trust and Elysium Healthcare have come together in partnership to build and manage a brand-new, dedicated mental health inpatient unit for young people.

The unit offers 12 inpatient beds for young people and a therapeutic, safe, and nurturing environment to support and aid recovery. There will be a variety of communal living and outdoor spaces to give young people the opportunity to socialise with their peers and be as independent as possible. There will also be an Ofsted registered school set up on-site to enable young people to continue with their schooling whilst receiving treatment.

Joy Chamberlain, Chief Executive Officer of Elysium Healthcare said, "Partnership working to deliver services in this way will create a new benchmark for the future, and we look forward to continuing to work with Surrey and Borders Partnership on this exciting journey."

Supporting this ambition, our Joint Commissioning Strategy outlines how our system architecture, will commission services for children and young people – for Surrey services, neighbourhood and individual level. Our vision is to support children and families holistically to live healthy and fulfilling lives', using improved understanding of needs across health and care services, hearing children and families' voices and managing our resources together.

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The strategy focuses on three main theme areas:

1. promoting and facilitating good health, emotional wellbeing, and healthy relationships;
2. recognising and promoting the importance of development and early learning; enabling partnership working and collaboration; and
3. recognising the benefit of fully inclusive services, communities, and neighbourhoods.

We will continue to use our learning from the development of current services such as iTHRIVE, HOPE service and care closer to home, to continue strong partnership working to achieve our ambition. The Helping Families Early Strategy, Children's Community Health Services re-commissioning, maternity transformation, the Fuller Stocktake and the Children's Digital Programme are significant enablers of this strategy.

Our vision for **Children's Community Health Services** is to meet the needs of children, young people and their families at the earliest opportunity, through providing timely support, advice and specialist delivery at home, within local communities and across the county's geographies. We aim to ensure healthy lives and a brighter future supports children to grow up safe and resilient by prioritising prevention, early intervention and addressing health inequalities, enabled by designing and delivering services across Surrey and at Place.

As a partnership, our improvement priorities include:

- Children with Disabilities - Social Care alignment to health services, including continuing care, speech and language therapy, occupational therapy, physiotherapy, community paediatrics, and child and adolescent mental health services (CAMHS)
- Personalisation - including increasing take-up of and streamlining personal budgets, direct payments and personal health budgets
- Health of Looked After Children and Care Leavers - better use of health assessments, and understanding of the mental and emotional health of these children and young people
- Ordinarily Available Provision - services to support children with additional needs in schools enabling those that work in universal services to know what is available in their communities
- Community Health Services - making sure waiting times are reduced, workforce issues are addressed, and services are more impactful on shared outcomes
- Children and Young People (CYP) with a diagnosable eating disorder receive timely access to treatment, irrespective of severity and maintain the delivery of the 95% achieving the national waiting times standards of 4 weeks for routine care and 1 week for urgent care.
- Vulnerable Adolescents - Anxiety & Suicide Prevention to address the rising numbers of young people who are experiencing mental health crises, heightened through the pandemic, particularly through our Targeted Youth Offer
- Neurodevelopmental Pathway ensuring practitioners and services come together around a family at every stage of their journey
- Post Adoption and Special Guardianship Order (SGO) support ensuring therapeutic provision to prevent adoption or SGO family breakdown

To ensure that children with additional needs and disabilities can access the right support at the right time, from local, high quality health services, we will deliver an integrated system across Health, Social Care and Education. As well as providing appropriate and easy transitions for young people into adult services, we are committed to developing a transition to adult services that is seamless. We will increase use of digital technologies and multidisciplinary teams within clinical pathways as the normal way of working to ensure we make the best use of our resources.

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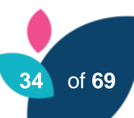

CASE STUDY

North West Surrey Alliance are using an innovative community platform to focus on supporting children and young people to achieve their potential, from birth through adolescence, education is a key to support health and wellbeing for all. Through a comprehensive approach we aim to support families with practical and emotional support, provision of opportunities for work placements and work experience to increase aspirations and develop children for a future Surrey workforce.

The Alliance has partnered with Coram Life Education and Home Start Elmbridge, who are raising funds to give children and young people in North West Surrey the best start in life, supporting their welfare, mental health and education.

For children and young people with complex needs and special educational needs and disability (SEND), our ambition is that Surrey children and young people aged 0 to 25 years will lead the best possible life. They will be able to access health information and will understand the services available when they transition into adult healthcare provision as part of 'Preparing for Adulthood' in higher education or employment, independent living, participating in society, and being as healthy as possible.

By 2028 our population will benefit from:

- Better managed long-term conditions with reduced unplanned hospital attendances and admissions plus reduced co-morbidities later in life.
- Improved health and wellbeing including improved school attendance for children and young people, breastfeeding rates, healthy relationships with secure attachment and early learning.
- Children will be seen in a more appropriate community setting instead of an emergency department whenever possible.
- Children's critical care will be provided closer to home whenever possible.
- Each child or young person with an Education, Health and Care plan will have high quality health provision to ensure their health needs are met in alignment with their educational outcomes within statutory timescales.
- Under school age children with Special Educational Needs, will have their health needs identified early.
- Children and young people, parents and carers will be able to access clear health information.
- Young People in Surrey will have access to the Health Services they need as part of Preparing for Adulthood.
- Health interventions in Non-Maintained Independent Educational Provision will meet standards in line with National guidance and expectations.
- Medical needs of Children and young people in Educational Provision will be met.
- All Young People with Learning disabilities and or autism in Surrey who are aged over 14 and over will have an annual health check.

You can read more about our children's services, strategy for looked after children and children's social care priorities in the Corporate Parenting Strategy on our websites.

Mental Health

We know that self-reported wellbeing has decreased significantly over the last 3 years; the combination of the impact of the Covid19 pandemic and cost of living has affected many people in Surrey and across the country. There is around a 20 year gap in life expectancy for people with

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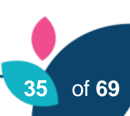
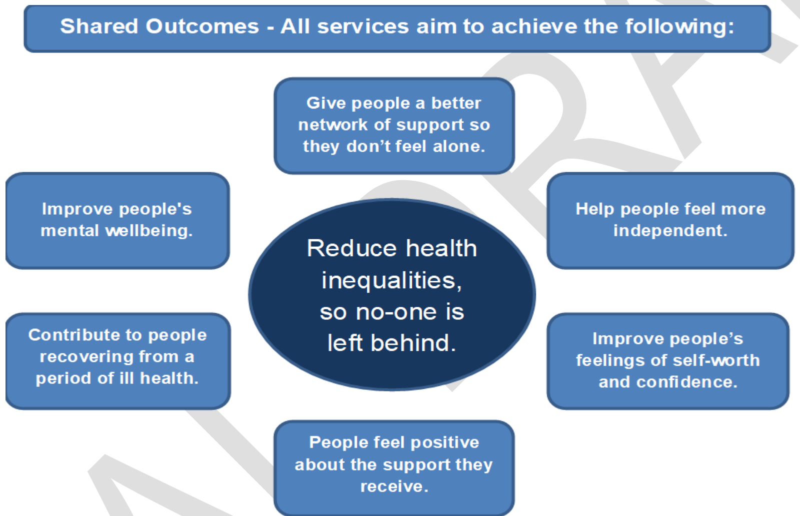


Serious Mental Illness (SMI)[2] and notably excess mortality[3] for those under 75 years is significantly higher in Surrey for SMI than the England average. In Surrey the percentage of citizens reporting high anxiety[4] is 22.5%, which while better than the England average (24.2%), is higher than the reported best (15.9%). This correlates with the increase in demand and use of all age mental health services in Surrey Heartlands.

Our ambition is that we will achieve the national mental health deliverables informed by the NHS Long-Term Plan and deliver the recommendations from the local Surrey Mental Health Improvement Plan. Through the Surrey Heartlands Provider Collaborative, we will develop an integrated approach to manage the interrelationship between physical and mental health, especially for those experiencing a mental health crisis.

Mental health is a priority in Surrey. Priority Two of the Health and Wellbeing Strategy is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing. Using this and the national drivers for change such as the Adult Social Care's Accommodation with Care and Support Strategy for people with mental health needs, the Mental Health Partnership board report and improvement plan outline areas for improvement in mental health services, with a focus on a more preventative and early help approach, improving access and preventing services gaps.



We are refreshing the Children and Young People's Emotional Wellbeing and Mental Health (EWMH) Strategy to support the development a culture of emotional wellbeing and mental health support for children and families based on prevention, strengthening early intervention, and building resilience. This work is closely interconnected with the delivery of our Best Start Strategy[5].

By 2028 our population will benefit from:

- Increased access to evidence-based care to an additional 24,000 women with moderate to severe perinatal mental health difficulties and personality diagnosis each year until March 2024. Care provided by specialist services will be extended from preconception to 24 months after birth and access will also be expanded to psychological therapies in services. A key priority was the development of a Maternal Mental Health Service, which was launched in December 2022.
- 24/7 psychiatric liaison in all emergency departments.

[2] Health and life expectancies - Office for National Statistics (ons.gov.uk)
[3] the number of deaths above the five-year average
[4] Public Health Outcomes Framework - Data - OHID (phe.org.uk) indicator C28d 2020/21
[5] Publication expected summer 2023.

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- 60% of people with a diagnosed severe mental illness receive an annual physical health check in a primary care setting.
- Increased access to psychological therapies
- Implementation of actions from the Suicide and Prevention Strategy 2022.
- A tailored service to young people between 18 and 25 years old who are experiencing mental health challenges.
- Working towards eliminating all inappropriate out of area placements.
- Supported the creation of an Adult Mental Health Alliance, which will help facilitate voluntary sector engagement with the health and social care system in a more strategic manner.
- Implementation of actions from the EWMH strategy, which provides the strategic framework for all partners in Surrey to improve EWMH of CYP and ensures commitment to the implementation of the I-Thrive framework.
- A much stronger focus on early intervention, with mental health support for children and young people embedded in all our schools and colleges.
- Implementation of Community Transformation and One Team approach for adult community services.
- Improving accommodation and employment support for people with poor mental health lead by SCC with ICS partners.
- CYP experiencing a mental health crisis able to access the support they need. This will be achieved by 100% coverage of 24/7 age-appropriate crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment function as well as being supported to prevent a crisis occurring again by being connected to support from early intervention offers.

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You can read more about our mental health programme on the Surrey Heartlands website.

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Dementia

In Surrey, people with dementia have a higher number of hospital admissions with longer lengths of stay and higher emergency admissions compared to people the same age without dementia. Whilst Surrey performs similar to or better than the England average[6] on the majority of the dementia care indicators, to meet the health and wellbeing strategy target of reducing emergency admission rates of people with dementia from 3,272 to 2,496 per 100,000 we must do things differently.

Our Joint Health and Care Dementia Strategy for Surrey sets out the collective ambitions we want to achieve across Surrey to improve the dementia care pathway in five parts:

1. Stopping people from getting dementia
2. Helping people who have just been told they have dementia
3. Helping people with dementia to live well
4. Supporting the care of people with dementia
5. Supporting people with dementia to live for as long as possible

[6] Joint Health and Social Care Dementia Strategy for Surrey 2022 – 2027, p10

By 2028 our population will benefit from :

- People can make good decisions about when to consider care and how to find the best choice for them, shown through improved outcomes.
- Information, advice and guidance offered ensures everyone accessing care and support for themselves or for someone else, can have the right information at the right time.
- People to know about the different options available to them locally in the community and how to get support to live independently.
- Increase in Surrey residents accessing day services and activities within their local communities to stay independent for longer.
- Enhanced services such as Advocacy and Stroke recovery, to continue people being enabled.
- Understanding that technology is not a preference for all residents and ensuring that other options are available to support, ensuring no one is digitally excluded.
- Continued research and development of initiatives to provide access to trials of new medications and treatments.
- Progressing actions from the Joint Health and Care Dementia Strategy for Surrey 2022 to 2027.
- Using new and existing technology to improve people's care choices and independence.

You can read more about the work to support these improvements in our Dementia Strategy.

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Learning Disabilities and Autism

We are using the national policy drivers to optimise outcomes for those with Learning Disabilities and Autism (LDA), including Building the Right Support Action Plan.

Our ambition is to make sure no one person is left behind for those with Learning Disabilities and/or Autism. We are using our local drivers including the Surrey All Age Autism Strategy, LDA Three year delivery plan, Joint Commissioning Strategy for Children and Young People, Children and Young People with Additional Needs & Disabilities: 2022 -2030 Sufficiency Plan and Surrey Accommodation Care and Support Strategy which outline the local response and actions to meet the national drivers and Surrey 2023 community vision.

People with a learning disability tend to have worse physical and mental health than the general population. We know that **women with a learning disability live 22 years and men 11 years less than their counterparts**. We will focus on specific and measurable actions that reduce the health gap between people with a learning disability and autistic people and the wider population, with the aim of achieving equivalence of care.

Good quality healthcare and effective access to Primary Care services are key to how we are tackling such inequalities. As some health problems experienced by people with a learning disability are simple to treat once diagnosed, a GP can often prevent a serious health condition with early identification. To this effect, an Annual Health Check is offered to anyone aged 14 or over who is on their GP's learning disability register.

By 2028 our population will benefit from:

- Delivering the workstreams in the All-Age Autism Strategy 2021 to 2026.
- Increase the number of people with learning disabilities on general practice register, receiving an Annual Health Check and effective Health Action Plan to prevent physical ill health and promote physical well-being.
- Numbers of individuals in inpatient settings reduces and stays below national targets – no more than 3 at any one time (adults, young people and children). Children and young people will be supported by key working service, with a digital dynamic support register and intensive support service.

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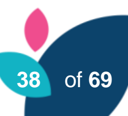

- Increase in Supported Independent Living (SIL) options, meaningful activities in the community and numbers of people in employment.
- We will have a workforce trained in learning disability and autism in line with the Health and Care Act 2022.
- Proactive Public Health targeted interventions to reduce health inequalities to decrease disease burden and prevent premature mortality.

You can read more about our Learning Disabilities and Autism work on the Surrey Heartlands website.

Elective Care

Our ambition following a significant reduction in elective services during the emergency phases of the pandemic, is that elective services recover to pre-pandemic levels. National data shows that the recovery rate for children's elective care has been at a slower rate than for adults and Surrey Heartlands replicates this.

Our aim is to reduce the volume of patients waiting long periods for admitted care and that they 'wait well' with the following objectives: no patient waiting over 52 weeks for elective care by March 2025; 95% of patient waiting six weeks or less for a diagnostic; and 75% of patients referred for a suspected cancer be diagnosed or have cancer ruled out with 28 days by March 2024.

We understand the impact longer waits have on our patients and their families. The safety of our patients is our top priority, and we will prioritise the most clinically urgent patients. We will continue to share information on a range of conditions to enable a better understanding of supporting your own health while on the waiting list – known as 'waiting well'. It is a key system priority to progressively reduce the volume and length of elective care waiting lists.

Delivering such a high volume of activity is costly and puts significant strain on an already pressured workforce. Surrey Heartlands will implement robust pathway changes that improve efficiency to deliver the same patient care across fewer episodes and with less cost.

We have successfully reduced our longest waits over the last 18 months, whereby now no one is waiting longer than 18 months and are now working to achieve no waits over 65 weeks (15 months) by March 2024. However, our plans will need us to do things differently, creating additional capacity within our system and changing for the better the way services are delivered, while giving patients more choice and control over their experience in the NHS.

Delivery of our elective recovery plan includes several initiatives:

- Significant investment in and reconfiguration of our diagnostic services, including standardisation of referral pathways and clinical criteria
- Collaborative systemwide working to reduce variation and standardise referral pathways into Single Points of Access (SPOA) models where appropriate.
- To identify opportunities to consolidate services in order to improve clinical outcomes, reduce variation and improve efficiency.
- Develop digital technology to support operational delivery of elective care, including integration of patient-facing digital technology with the NHS app.
- Development of care models to consolidate attendances, provide flexibility to arrange own follow-up appointments and expand capacity to deliver high-quality care

Services for people with a range of rare and complex conditions, often involving treatments for those with rare cancers, genetic disorders or complex medical or surgical conditions known as Specialised Services, has a large Clinical Transformation Programme in line with national Long-Term Plan and strategic priorities. As part of the development of a 3 year Forward View and Strategic Plan for specialised services during 2023/24, a strategic review of our Clinical Networks

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will be incorporated to establish and manage the Specialised Services Operational Delivery Networks (ODNs) across South East England.

From 1st April 2024, NHSE aims to delegate some specialised services commissioning responsibility to ICBs such as critical care, neonatal care, cardiac care, renal dialysis, and some cancer care. This will enable a real opportunity in Surrey Heartlands to join up specialised and non-specialised patient pathways to truly improve the health of local populations and integrate care pathways – from prevention to primary care, through to secondary and highly specialised care.

Our **outpatient services** see by far the great volume of NHS. Demand for these services continues to increase with improved care treatments reducing the need for admission and waiting lists created because of the pandemic. We will improve demand management to reduce the volume of patients being seen in an acute setting unnecessarily and redesign care pathways to include opportunities for patients to seek support and guidance from appropriate alternative health and care professionals, such as optometrists with more effective and timely advice and guidance (A&G) to primary and community care services.

Surrey Heartlands has already made significant progress improving **cancer services**. We have met the cancer 28 day Faster Diagnostic Standard (FDS) during 2022/23 and are committed to deliver the core cancer waiting time standards: 28 days to diagnosis; 31 days from referral to decision to treat; and 62 days from referral to first definitive treatment. Maintaining excellent cancer pathways is one of our key aims, supported by the Cancer Centre at Royal Surrey Foundation NHS Trust and the Surrey and Sussex Cancer Alliance.

Through our Cancer Centre and Surrey University, we aim to deliver research and innovation in cancer, offering patient trials and new technologies where available. By implementing new technologies, changes to screening protocols and best practice timed pathways will all enable Surrey Heartlands to continue to deliver one of the best cancer performances in the country.

We are increasing **diagnostic provision** to meet the needs of the population and transform services to ensure patients are diagnosed faster, earlier, more efficiently and are able to be prescribed the most appropriate course of treatment, thereby improving patient experience and outcomes.

We will develop our Diagnostics Strategy during 2023, with the expectation to publish at the end of September 2023. This will see the implementation of the recommendations from the Diagnostics: Recovery and Renewal, meaning we will expand existing Community Diagnostic Centres to ensure patients can access a range of diagnostics closer to home, ensure effective collaboration between different workstreams such as cancer diagnostics and NHS@home; and develop a sustainable and resilient workforce.

By 2028 our population will benefit from:

- Improved access to specialist advice – providing greater flexibility in how advice from clinicians is accessed by patients, enabling more timely, convenient and appropriate care and avoiding the need for unnecessary appointments.
- Improved patient pathways - reducing avoidable delays by ensuring we are making the best use of the latest technology, clinical time and expertise.
- Expanding community diagnostic centres - focusing on ease of access and convenience for patients.
- Care is more personalised – more choice and options to reflect patient preferences and needs.
- Targeted support for patients – patients are informed, supported to wait well and co-develop personalised plans to prepare for treatment.

You can read more about the planned care delivery plans in our Fact Files on our website.

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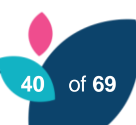

2.2. Delivering NHS Long Term Plan Priorities

"When I need it, I get the right care, in the right place, and I am empowered to self-manage my condition."

We know that life expectancy has increased over the years since the NHS was founded, and different types of diseases are becoming more common. Mortality from heart and circulatory diseases has declined by more than three quarters over the last 40 years. But we have seen an increase in the number of long term conditions – illnesses which last longer than a year, often worsening with time – which are responsible for a substantial amount of poor health and demand on health and care services.

There have been slower improvements in the number of years of life lost particularly for **cardiovascular, stroke, respiratory conditions and diabetes**. The NHS Long Term Plan (LTP) set out a number of improvement priorities which we have been working on and achieving over the last five years. There are still improvement ambitions we want to achieve for our population; some going beyond what is required, to ensure no-one is left behind.

Our Medical Directors and professional clinical body are developing an ICS Clinical Strategy, which we expect to publish in Summer 2023. This will align with organisation clinical strategies and support the delivery ambitions of the Provider Collaboratives through the coordination of care into a single or coherent process forming clinical integration. As part of this focus, we are leading specific work to reduce clinical unwarranted variation - variation that cannot be explained by illness, medical need, or the dictates of evidence-based medicine – to realise optimal health outcomes.

In this chapter we describe our delivery and outcome ambitions for these LTP priorities.

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Cardiovascular

The NHS Long Term Plan's national ambition is to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years and has agreed a set of ambitions which seek to improve the detection and treatment of the high-risk conditions including **Atrial Fibrillation (AF), Blood Pressure (BP) and Cardiovascular Disease (CVD)**.

Our ambition for the Cardiovascular programme is to support the NHS Long Term Plan objective through our local priorities:

- Heart Failure Management
- Atrial Fibrillation detection and management
- Hypertension detection and management
- Cholesterol management
- Cardiac Rehabilitation
- Improving efficiencies and embracing patient initiated follow-ups (PIFU), Advice & Guidance and Virtual consultations

CASE STUDY

Heart Failure patient placed on the transplant waiting list following successful rehabilitation with First Community's cardiac rehab physiotherapists.

Mr George was treated at Harefield Hospital, Uxbridge to undergo surgery to attach a Left Ventricular Assist Device (LVAD) to his heart. He was referred to **First Community's Cardiac Rehabilitation Service** as he was not deemed well enough to be on the heart transplant waiting list. The team of physiotherapists conducted routine fitness assessments and medical checks early on, to enable them to plan a comprehensive rehabilitation programme for Mr George.

Mr George has been accepted and is well enough, to go onto the heart transplant waiting list and said, "The First Community team has left an indelible mark on me; the experience has been ecstatic and the support the team has given me has been amazing."

By 2028 our population will benefit from:

- Identification of a minimum of 85% of patients at risk of AF and of those patients:
- 80% of patients with high blood pressure to be identified and of those, 80% to be treated
- 75% of people aged 40-74 to have received a formal validated CVD risk assessment and cholesterol reading recorded.
- 25% of people with Familial Hypercholesterolaemia (FH) are to be diagnosed and treated optimally.
- Increase identification of Heart Failure diagnosis

You can read more about our cardiovascular delivery plan in our Fact File on our website.

Stroke

The NHS Long Term Plan's ambition for stroke care includes developing improved post-hospital stroke rehabilitation models, delivering a ten-fold increase in the proportion of patients who receive a thrombectomy after stroke and delivering improved thrombolysis performance with access to all patients who could benefit.

Integrated Stroke Delivery Networks (ISDN) are an integral part of delivering the LTP commitments for stroke. The Frimley and Surrey Heartlands ISDN aims to improve the quality of stroke care, through improving clinical outcomes, addressing areas of unwarranted clinical variation, excellent patient experience and patient safety. The ISDN brings together key stakeholders and partners to collectively agree a strategic plan of work to facilitate service improvements across the whole stroke pathway, ensuring a patient centred, evidence-based approach to delivering transformational change. Stroke, alongside paediatrics and maternity, are being reviewed across Surrey Heartlands as part of the provider collaborative discussions. The Frimley and Surrey Heartlands ISDN will support and inform any end to end stroke pathway transformation discussions providing subject matter knowledge and expertise.

The ISDN has developed 3 key workstreams:

1. **Prevention** - The development of a stroke prevention strategy is linked with the cardiovascular disease programme.
2. **Acute and Urgent Care** - This workstream brings together clinicians (including Stroke Consultants, nursing and therapy staff) and service managers working across the acute hospitals within the ISDN, representatives from SCAS and SECAmb, nursing staff within the Early Supported Discharge Teams, GP leads and the Stroke Association. Key priorities include **SSNAP Performance, Transient Ischaemic Attack Pathways, Pre-hospital pathway and Thrombectomy Pathway.**
3. **Rehabilitation and Life after Stroke** - delivering the Integrated Community Stroke Service Model (ICSS), improving the intensity and access to rehabilitation across their geographies and ensuring the integration of social care in the delivery of stroke rehabilitation.

By 2028 our population will benefit from:

- As part of the joint CVD / stroke prevention strategy, significant and sustained improvements will have been made in the identification and treatment of hypertension and atrial fibrillation within the population
- Thrombolysis and thrombectomy rates will have increased significantly and the LTP ambitions for thrombectomy achieved
- Pre-hospital video triage will be 'business as usual' within the Stroke pathway

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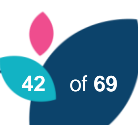

- CT Perfusion will be available across all Acute Stroke Centres within the ICS and the NOSIP fully implemented
- Routinely admitting stroke sites will consistently achieve SSNAP 'A' ratings
- Agreed rehabilitation data sets will ensure that quality and quality measurement is at the heart of the stroke rehabilitation model. They will enable ongoing service evaluation, performance review and outcome measurement, thereby supporting continuous service improvement and development
- Quality equitable care will be delivered across the Stroke pathway, including sustainable stroke specific rehabilitation with opportunities for mutual aid in times of need
- Patient and carer experience will be embedded as an integral element informing and developing ongoing pathway development and quality improvement

You can read more about our stroke delivery plan in our Fact File on our website.

Respiratory
The NHS Long Term Plan's ambition is to improve treatment options and reduce the impact on those with the condition through prevention and self-management developments. Our ambitions for those with respiratory conditions are for:

- Appropriate treatment and support, enabling self-management and access to services when needed. Through this, we will transform our outcomes so that they are to equal, or better than, our international counterparts.
- People admitted to an acute or mental health hospital who smoke will be offered NHS-funded tobacco treatment services. The model will be adapted for expectant mothers and their partners.
- Transform Pulmonary Rehabilitation services by increasing capacity, improving accessibility, and to enable patients to be empowered to self-manage their condition by working with system health and care partners and voluntary organisations.
- Achieve economy of scale with ensuring developments are made jointly with cardiovascular disease and cardiac rehabilitation, prehabilitation and moving from reactive treatment post event to prevention.

Around a third of people with a first hospital admission for chronic obstructive pulmonary disease exacerbation have not had a previous diagnosis. Surrey Heartlands has commenced a programme of reducing variation in quality of spirometry. We are re-introducing access to training and reviewing locally commissioned services to enable consistent provision.

Asthma is the most common long-term medical condition in the UK, with around 1 in 11 children and young people living with asthma, with outcomes exacerbated when living in the most deprived areas. We know that the UK has one of the highest prevalence, emergency admissions and death rates for childhood asthma in Europe. Surrey Heartlands is acting to improve early diagnosis such as improving access to diagnostics, implementing breathlessness pathways, using medicines optimisation and improving the asthma pathway for children, young people and adults through implementing the national bundle of care objectives.

Smoking rates in Surrey are below the national average and are continuing to fall. But we know that smoking rates are much higher among our more deprived communities, having a significant impact on increasing health inequalities by reducing life expectancy by up to 20 years and that smokers are 36% more likely to be admitted to hospital. Research from Action on Smoking and Health (ASH) estimates there are about 87,000 households in Surrey with at least one smoker; 21% of households with a smoker fall below the poverty line. If these smokers were to quit, around 6,000 households in Surrey would be elevated out of poverty. Surrey Heartlands will implement the

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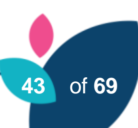

tobacco prevention model for inpatients (acute and mental health patients), adapted for expectant mothers and their partners.

By 2028 our population will benefit from:

- More patients will have access to testing, such as spirometry testing, so that respiratory problems are diagnosed and treated earlier
- Patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers
- Expanded rehabilitation services, including pulmonary rehabilitation and digital tools so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible
- Improved treatment and care of people with pneumonia
- Lowest smoking prevalence rate in England

You can read more about our respiratory delivery plan in our Fact File on our website.

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Diabetes

Our ambition is to improve the lives of people with or at risk of developing diabetes across Surrey Heartlands. Identifying people earlier and providing equitable access to education and services. We will empower our citizens to manage their diabetes or reduce their risk by raising awareness, providing quality education programmes and by reducing variation in care provision and clinical outcomes.

We will achieve this by working together across healthcare, social care, and voluntary sector ensuring the care we provide meets the needs of our population and is of the highest quality. The Diabetes Strategy was derived from these ambitions and together with drivers such as the NHS Long Term Plan we aim to ensure local diabetes services are equitable and accessible by all.

Around 50,000 people in Surrey Heartlands are diagnosed with diabetes. In addition, there are approximately a further 66,118 people at a higher risk of developing type 2 diabetes[7].

The Surrey Heartlands Diabetes Strategy sets key ambitions to drive an improvement:

- Improve performance in the annual National Diabetes Audit for people with diabetes receiving all eight NICE Care Processes (8NCP) and achieving the three Treatment Targets (3TT) across our lowest 50% of practices.
- Reduce hospital admissions for cardiovascular and renal disease.
- Ensure inpatients with diabetes in our hospitals, admitted for any condition, receive effective care of their diabetes. Wherever possible they will be actively involved in decisions concerning management of their diabetes.
- Develop diabetic foot care services, increase capacity to reduce waiting times and reduce rates of lower limb amputations.
- Ensure people newly diagnosed with diabetes attend structured education within one year of diagnosis.
- Early identification of non-diabetic hyperglycaemia (NDH) and referral to prevention and weight loss programmes such as the NHS Diabetes Prevention Programme (NDPP).
- Support people with diabetes to use existing and emerging technology to support their diabetes care and self-management.

[7] https://fingertips.phe.org.uk/profile/diabetes-ft/data#page/3/gid/1938133138/pat/44/par/E40000005/ati/154/are/E38000177/iid/92952/age/164/sex/4/cat/-1/ctp/-1/cid/4/tbm/1

By 2028 our population will benefit from:

- Reduction in unwarranted variation including access to services and achievement of treatment targets across the ICS.
- An increase in people taking an active role in managing their condition.
- Reduction in development of diabetes related complications such as number of major and minor lower limb amputations.

You can read more our diabetes delivery plan in our Fact File on our website.

By reducing pressure on our health and care services over time, we create the space for our workforce to provide care quality with continuity of care and do much more on preventative care to support people to stay well for longer. The following chapter focuses on care quality, safety, personalised care plus equality, diversity and inclusion.

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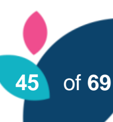

2.3. Providing Quality, Safety and Continuation of Care

"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 clinician or care professional, need."

Core to our ICS strategy are the principles of **quality and equitable care, patient safety and tailored care that supports patient choice**, whenever possible in line with the National Quality Board principles. Quality threads through everything we do an ICS. This section summaries our approach.

Our ambition is to improve quality by creating a culture that is focused on continuous improvement and learning, ensuring that our health and care services provide people with safe, effective, responsive, caring, well led, and compassionate services, where innovation is encouraged and is safe.

In Surrey Heartlands, we are strengthening partnerships with staff, local communities and people using services to deliver higher-quality care and tackle health inequalities and ensuring that decisions are taken closer to the communities they affect, so that they are more likely to lead to better outcomes. We strive to provide people with an improved experience of health and care, as services are more coordinated, focused on addressing health inequalities and based on the latest evidence, learning and best practice.

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All of Surrey Heartlands NHS provider trusts are rated 'good' or 'outstanding' overall. 85% of adult social care services are rated 'good' or 'outstanding and 93% of GP Practices are rated 'good' or 'outstanding'.

We are committed to continuous care quality improvement at every level of our system and have established the Quality Improvement Collaborative (QIC) to drive our quality governance model across Place-based areas and the ICS. Surrey Heartlands' Quality Management System Framework has been developed with partnership organisations building on existing quality governance principles, delivery mechanisms and the joint commitment to the delivery of care that is effective, safe and provides as positive an experience as possible.

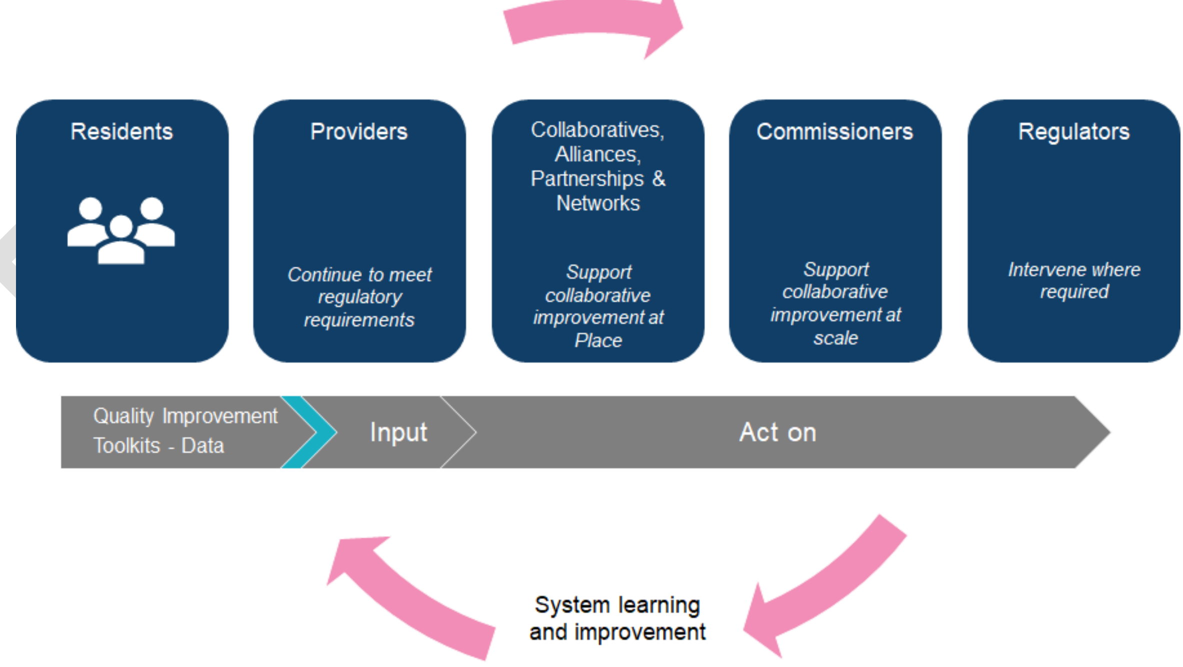

Figure 9 - System by Default, ICS Quality Management System

We will continue to use our System Quality Group (SQG), formed from ICB, Trusts, Public Health and Regulators, to provide a strategic, integrated forum to inform decision making and risk management to improve quality of care for those who use our services. You can read more about our care quality improvement monitoring and management in our website Fact File.

The Surrey Heartlands Quality Improvement team support the system to use improvements approaches where quality improvement is required either from across the system - trusts, place or neighbourhood level. By learning from patients, staff, and partners we aim to ensure high-quality governance, patient safety, and risk mitigation. We will continue to utilise the national Commissioning for Quality and Innovation (CQUIN) approach to embed sustainable care quality and patient safety improvements in Surrey Heartlands.

CASE STUDY

Royal Surrey's Maternity Services Team undertook an innovative project to look at how the team received feedback about their service from women using it, particularly hard-to-reach groups. The team recognised that the existing channels they were using did not represent their target audience fairly.

As the team was involved in developing new maternity hubs in local communities and setting up assigned small teams of midwives to see women through pregnancy and birth, it was keen to gather feedback to further develop its services.

Led by Clare Cardu, Transformation Lead Midwife, the team explored how women's voices could be better heard. The solution they came up with was to use a patient experience service (PEP Health) to automate collection of online feedback from social media platforms.

Amy Stubbs, Deputy Director of Midwifery and Head of Nursing, Women and Children's, said: "The ability to collect feedback from a broad range of online platforms has been invaluable, giving us a rich resource for understanding patients' experience of our maternity services. The feedback is then shared regularly among all areas of the service and helps us to keep learning and improving".

This project won the **HSJ Patient Safety 2022** award for **Maternity and Midwifery Initiative of the Year** for a patient-led service development project entitled 'Hearing the True Voice of Women'.

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Patient Safety

We will build into our care quality, **a patient safety culture** and **a patient safety system** with three strategic aims:

1. **Insight** - improving understanding of safety by drawing intelligence from multiple sources of patient safety information
2. **Involvement** - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
3. **Improvement** - designing and supporting programmes that deliver effective and sustainable change in the most important areas.

Nationally there are over 700 Patient Safety Specialists including at Executive level. Within our NHS trusts and through the ICS, we are providing leadership and support to patient safety activities across their organisation. We will provide mandatory patient safety training for all staff in conjunction with Health Education England in collaboration with Academy of Medical Royal Colleges (AoMRC).

We will continue involving patients, families and carers in their own safety through our Patient Safety Specialists. Our Patient Safety Specialist Network will continue to provide the opportunity to share concerns and sharing learning across the whole health and care system to work more collaboratively through regular workshops.

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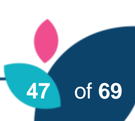

Infection and Prevention Control

Our overarching aim is to continually improve quality of care by reducing the risk of avoidable harm from Health Care Associated Infections (HCAI) and other communicable diseases.

To achieve this, we will have in place governance oversight processes to monitor and receive assurance on the following strategic objectives:

- Being person centred- listening to all our service users
- To build ICS specialist IPC workforce capacity to collaborate and support provider services to deliver safe care
- To support health and social care providers to maintain compliance with the code of practice on the prevention and control of infections and related guidance, to deliver safe and effective and reduce risk associated with HCAI
- To capture and share meaningful system wide learning from incidents and outbreaks, to drive IPC quality improvements across all health & care settings
- Maximising financial capacity

Medicines Optimisation

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.

Our medicines optimisation goal is to help patients to improve their outcomes, take their medicines correctly, avoid taking unnecessary medicines, reduce wastage of medicines and improve medicines safety.

We have identified key priority areas of work from a pharmacy and medicines optimisation perspective to support the organisation in delivering its strategy and overarching key ambitions including the Critical Five, implementation of the recommendations from the Fuller Stocktake report next steps for integrating primary care and include:

- **Workforce** - The overarching ambition is to develop a collaborative pharmacy workforce with the ability to provide integrated pharmacy services to patients across Surrey Heartlands. This will ensure that we provide high quality medicines related care for those who need it, in the right place, at the right time, by the right person; working innovatively and in partnerships across our services to better serve the population and make Surrey Heartlands the best place to work (for the pharmacy workforce) in line with the NHS people plan.
- **Medicines Safety** - Developing an open, learning, and safer culture locally is a high priority across Surrey Heartlands. This aligns with the aims of the Medicines Safety Improvement Programme (MedSIP), one of the workstreams within the wider National Patient Safety Improvement Programme, which is to reduce severe avoidable medication-related harm by 50% by 2024 and the third WHO Global Patient Safety Challenge: Medication Without Harm
- **Antimicrobial Medicines Optimisation** - with a focus on reducing unwarranted variation in prescribing, improving prescribing standards and reducing harm from inappropriate antimicrobial use aligned to the UK five-year national action plan. Priority areas of work include management of UTIs, review of co-amoxiclav prescribing and alignment of secondary care clinical guidelines.
- **Community Pharmacy** - to fully embed all services included in the national Community Pharmacy Contractual Framework. The ambition is for community pharmacies to be:
  - the preferred NHS location for treating and where appropriate testing for minor health conditions, promoting patient self-care
  - taking pressure off our local urgent care, out of hours services and GPs, reducing waiting times and offering convenient care for patients (including CPCS)
  - become established as healthy living centres, helping local people and communities to stay healthy, identifying those at risk of disease and reducing health inequalities.

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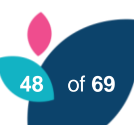

- support key local and national NHS targets and quality improvement initiatives such as tackling antimicrobial resistance, improving vaccination uptake rates.
- continue to ensure patients can safely and conveniently access the medicines they need as well as doing more to improve patient and medicines safety.

Dispensing doctors and dispensing appliance contractors form part of our delegated responsibility for Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services and Pharmaceutical Services. Work will be undertaken with Pharmaceutical Services providers to support integrated, collaborative working in order to deliver a more joined up preventative and personalised care for the population of Surrey Heartlands.

Supportive Learning Culture

We are working together in complementary ways through our joint commitment to the delivery of care so that it is effective, safe and provides as positive an experience as possible. This will demonstrate improvements in both population and clinical outcomes and provide clarity on roles, responsibility and accountability.

Key to this approach is ensuring subject matter experts from all sector partners are given the platform to collaborate to work together, agree quality outcomes, intelligence requirements, support innovation and standardise good practice (Figure 10).

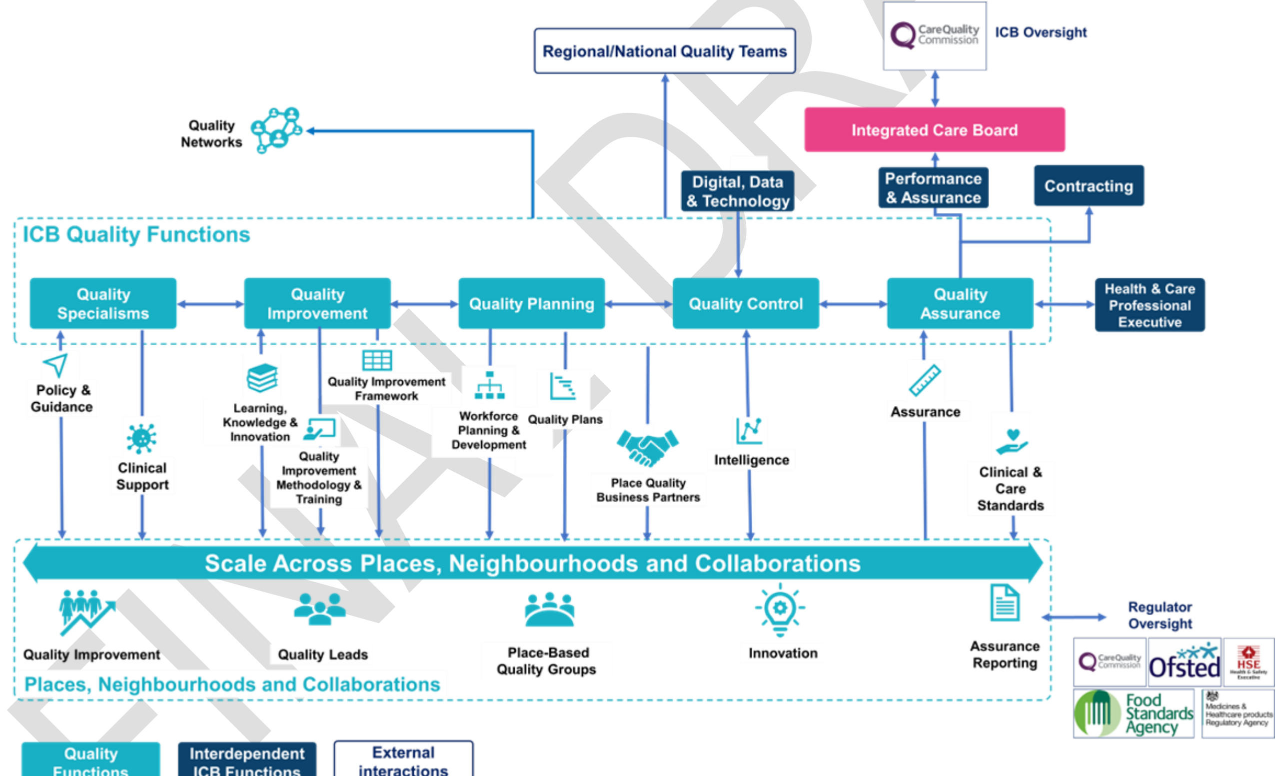

Figure 10 - Surrey Heartlands integration and governance

You can read more about the metrics and monitoring used to assure our delivery in appendix 3.

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Safeguarding and Domestic Abuse

The safety and welfare of children and adults, alongside the protection of those with care and support needs from abuse and neglect is of paramount importance to NHS Surrey Heartlands.

Our safeguarding team provides strategic leadership, expert advice to our partner organisations and ensures all services provide high quality, safe and effective care. Using the NHS Safeguarding Accountability and Assurance Framework ensures improvements in health outcomes for those with support needs.

A significant proportion of adults who need safeguarding support may be experiencing domestic abuse (DA). Our vision is for every adult and child experiencing domestic abuse to be seen, safe and heard, and free from the harm caused by perpetrator behaviour. As a partnership, we will focus on preventing domestic abuse and ensuring all children, young people and adults affected across their lifespan:

- Can access the right information, services and support, at the right time in the right place.
- Are empowered to live lives free from domestic violence or abuse.
- Gain the personal confidence to build healthy relationships for themselves and their dependants.
- Perpetrators are held to account and change their behaviour.

Our priorities are threefold:

- **Community** - To break the silence about domestic abuse within our local communities and remove the barriers that make it hard for survivors and perpetrators to reach support.
- **Professionals** - To maximise every opportunity to identify and respond to domestic abuse for survivors and perpetrators.
- **Expert support** - To empower specialist expert support to work with survivors, children and perpetrators in a way that achieves safety, with minimum reliance on external resources.

You can find out more information about domestic abuse on Surrey County Council, our joined-up approach to tackle Violence Against Women and Girls in Surrey and support on Health Surrey websites. To find out more about our safeguarding work, visit the Surrey Heartlands' Safeguarding webpages.

Equality, Diversity and Inclusion

Surrey Heartlands aims to be a leader in promoting equality, diversity, and inclusion (EDI). We believe that our organisation must reflect the full diversity of the communities and people it serves, both in employment and service delivery.

Public sector organisations have specific duties that need to be fulfilled. The general duty has three aims:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people from different groups; and
- Foster good relations between people from different groups.

Our particular duties relate to:

- **Equality -** we want everyone to have equally good health and care. However, the term 'equality' is sometimes used to describe equal treatment, care or access for everyone regardless of need or outcome.
- **Equity -** we want fair outcomes for everyone. What is important is addressing avoidable or remediable differences in health between groups of people.

Figure 11 -demonstrates that to achieve equity, some groups may need more or different support or resources in order to achieve the same outcomes. Ideally, the barriers would be removed for everyone, so adjustments wouldn't be required. However, this is not always possible.

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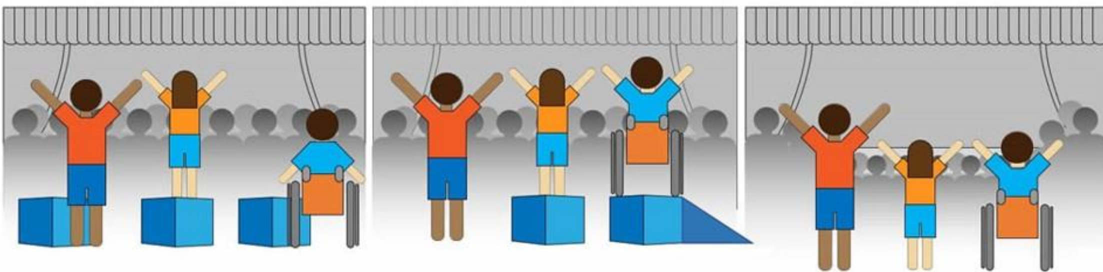

Equality – everyone gets the same resources	**Equity** – everyone gets the same outcomes, with resources distributed according to need	**Equal outcomes** – through the removal of structural barriers

Figure 11 - Characteristics of people or places associated with differences in health outcomes (Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk))

We are seeking to gain insight and research from local communities and support in developing culturally appropriate interventions through the use of Equity Development Officers and programme leads, which is being piloted in East Surrey Partnership, with the potential for use across the system. We will enact the targeted actions to address prejudice and discrimination as set out in the NHS equality, diversity, and inclusion improvement plan.

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CASE STUDY

Perinatal Equity Project is being led by Surrey Minority Equality Forum in Woking, Spelthorne, Reigate and Banstead focusing on pregnancy and the first two years of a child's life to provide information and support to families, pregnant people and new parents to improve their experience of pregnancy and parenthood in Surrey.

Community Activity Champions are working to remove barriers preventing women from being active. Through trusted community leaders, women are taking up activities benefiting their wellbeing, families and community.

Our ambition for our **Contingency, Asylum, Refugee, Evacuee and Migrant Service** that it is equitable, agile, and coordinated for all the different schemes to enable the most effective support for these vulnerable people across the health and care system. This starts with GP registration and initial health care check to assess the level of health needs following entry into the country, with appropriate follow up and support.

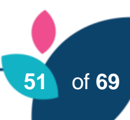
You can read more about our Equality, Diversity and Inclusion workforce approach in chapter 3 and more about our Equality, Diversity and Inclusion work on our website.

Personalisation and Patient Choice

Surrey Heartlands believes that personalised care and patient choice are fundamental to helping people to stay well for longer as part of a joined-up approach to health and care support. This gives people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life.

Our ambition is to ensure our citizens have choice and control in the way their care is planned and delivered, building skills, knowledge and confidence to support them to live independent lives and improve outcomes. That they can access outstanding quality and tailored care and support and find adult social care fair and accessible with a workforce that is enabled to deliver these commitments.

Our work will continue to assure and enforce patient choice principles across all our partners and through our professionals by ensuring:



- Patients are aware of their choices, including their legal rights, and actively seek and take up the choices available to them.
- GPs and referrers are aware of and want to support patients in exercising the choices available to them.
- Patients, GPs and referrers have the relevant information to help patients make choices about their care and treatment.
- Choice is built into service development plans, contracting arrangements and provision.
- Choice is embedded in referral models, protocols and clinical pathways.

By 2028 our population will benefit from:

- Our providers retain CQC ratings of either 'good' or 'outstanding' across our system
- An integrated population outcomes and clinical outcomes dashboard
- Delivery of our ambitions against the Patient Safety Strategy and Infection Prevention and Control Strategy
- Improvements in Quality Improvement methodologies are equitable and embedded across the system
- Social prescribing link workers are part of admission & discharge pathway to enable post discharge support
- Being connected to non-medical, community- based activities and support to build networks and resilience, tackling loneliness and isolation
- Supported referral into services offering help on social determinants of health e.g. housing, homelessness, energy, debt, welfare
- Being safe and feel safe (community safety including domestic abuse, safeguarding)
- Greater choice and control of the care and treatment

You can read more about Personalised Care on NHS England's website.

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3. What We Need To Deliver These Ambitions

"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 clinician or care professional, need."

So we can be a mature, productive and effective system and deliver our ambitions, we need a number of other functions to be working well. This chapter presents our priorities to enable achievement of our ambitions.

People and Culture

We know that building a sustainable workforce is one of the greatest challenges facing our organisations and the integrated systems we are developing with partners today. There are well documented challenges – high waiting times from stretched capacity, falling retention and staff satisfaction, a difficult labour market, declining public satisfaction and a worsening financial environment. We must address these problems in ways which also enable the improvements and developments in care described in this plan.

The Fuller Stocktake calls for new ways of bringing our people together – through integrated neighbourhood teams that organise themselves around local population health needs – so we can provide more holistic care for the most vulnerable members of our community. Meanwhile, developments in elective care will require a more mobile and shared workforce.

At the heart of our vison is a 'united team', aiming to share ways of working (a shared system culture), which connects us more and better and drives better connected resourcing, sharing talent and expertise across partners and sectors. Our United Surrey Talent strategy describes how we will utilise six change levers (Figure 12) to transform ways of working and career development in Surrey Heartlands through a series of process and collaboration changes (Figure 13).

Figure 12 – Six levers for change, (ICS Strategy United Talent, 2022)

Figure 13 – Areas of change (ICS Strategy United Talent, 2022)

The scale and pace required of these changes will only be possible through a connecting culture that speaks to the 'how' and 'why' and not just the 'what' we do together, to drive innovation, shared learning and spread across our partner organisations and local people. We have launched a workforce innovation fund to stimulate change and test ideas for scaling across our system, with over 30 pioneer projects in place.

Fundamental to the integrated neighbourhood teams is 'how' they connect. We are helping to shift the focus from services, systems and diseases to local population health needs and human connection through our cultural development work, 'Connecting Surrey Heartlands'. Working at

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neighbourhood, Place and ICS levels, we are focusing our attention on those things that are already working and using a systematic and science-based methodology, social research, to understand what and why people connect well and the conditions that enables and breeds success for effective change.

Developing our future workforce and Team of Teams

With over 40,000 jobs in the county, we can offer local talent a whole range of opportunities, including across career pathways, different settings and flexible work to suit.

We should not over-rely on overseas recruitment and as living in Surrey is expensive, we need to grow our own talent. This includes offering more opportunities to students at local education providers and reaching out to wider talent pools such as helping people with disabilities, armed forces backgrounds and those from care to support them find new careers in our services.

With Surrey County Council, we are establishing the Surrey Heartlands Health & Social Care Academy to help build, develop, share, and nurture talent across all settings incorporating social care sector staff. As an example, the Academy will help equip staff better to look after residents and patients at home. This is a win-win; helping people stay well at home whilst professionalising this important staff group with skills and better reward. With changes in care models, there will also be significant increase in academy types of support, such as diagnostics and frailty, where coordinated and focused support will be created for these priority pathways.

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Such is the scale and breadth of opportunities across our organisations, we will trial a career guarantee by offering two jobs at the same time in some career pathways – your first role and a conditional offer for your next move.

CASE STUDY

Inspiring students to take up NHS careers

150 students and parents from local secondary schools and colleges were given behind the scenes access and expert demonstrations from teams at East Surrey Hospital in an inspiring careers event.

Local students in year nine or above were invited to our 'meet the practitioner' careers event. They were able to watch demonstrations from doctors, nurses and therapists in the simulation suite, learn life-saving CPR techniques in 're-start a heart' style workshops and attend a range of presentations about different careers in healthcare.

The event was delivered together with Surrey Heartlands Health and Care Partnership, and First Community Health and Care with support from London Southbank University and University of Surrey. Students from 29 schools and colleges attended.

Both provider and Neighbourhood Teams will be enabled to form teams of teams so they can work across settings. Digitisation and data will be key; we will draw on the National digital staff passporting developments to help easy mobility of teams between organisations, we will increase access to shared care data and implement the required deployment systems, such as rostering and temporary staffing solutions.

We will build on our collaborative with Frimley and Buckinghamshire, Oxfordshire and Berkshire ICS to unite temporary staffing across Surrey, with fair pay and access to work, whilst incentivising the take up of permanent careers with our partners.

Access to our one public estate and related digital infrastructure will continue to augment – helping staff with more flexible working, getting the job done wherever they are and increasing opportunities for our teams of teams to come together physically.

Examples where increased mobility will be prioritised include elective and diagnostic activity across our provider collaborative, integrated neighbourhood teams and temporary staffing across all providers. We will develop our ambitions for workforce transformation in community and acute settings as the ICS clinical strategy emerges during 2023/24.

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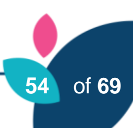

Looking after our people

Health and care is about teamwork. We want to see Surrey develop a core offer for our people, where everyone on the team has access to the same or equivalent support and reward. We have established a mental health support hub and are finding innovative ways to ensure this can be accessible to the many small VCSE organisations as well as the larger NHS Trusts.

CASE STUDY

Working with NHS Practitioner Health & Doctors in distress, Surrey Heartlands offers a supervision programme to support for GPs who are having mental health issues. General Practitioners who often work on their own for long hours need to be able to share issues that they are dealing with in a safe and blame free environment, so they are not reliant on family members or colleagues who may have burdens themselves and might be conflicted.

The programme is designed to improve GPs wellbeing, offer confidential safe place to help prevent escalation of mental problems and reduce the risk or suicidal thoughts. Over time the programme could be rolled out to wider groups of staff across primary care and beyond.

Cost of living has hit staff hard. We struggle to attract and retain staff in a county which is beautiful but expensive. We are working with Surrey County Council on its housing strategy for more affordable accommodation and on ways to improve the pay for social care workers. Meanwhile, the NHS continues to rely on recruiting international workforce and Surrey Heartlands ICS has invested significant amounts on recruiting world-wide.

The benefits of a diverse workforce cannot be overstated especially as it provides opportunities to recruit from a wider pool of candidates and projects a positive image of an inclusive organisation.

A corresponding investment in training, resources and awareness on Equality, Diversity and Inclusion to support its diverse workforce will contribute to additional recruitment, support the retention strategy and lead to increased productivity.

Leadership and Health and Care Professional Development

Surrey Heartlands' ambition is to create a diverse range of multi-professional leaders and representative professional leadership model that reflects our clinical and care professionals, and the diversity of our population across the full range of partnerships, health and caser services through the commitment to improvement on behalf of residents and partner organisations. This is central to designing and delivering integrated care and meeting the complex needs of people, not conditions.

CASE STUDY

The University of Surrey is partnering with the University of Exeter, to support the development of this new and innovative curriculum for a **new medical school**. It will offer a 4 year, graduate-entry bachelor's degree medical programme and expects to welcome the first cohort of 40 students in 2024.

We will provide improved and integrated services to Surrey residents by having effective and integrated system leadership that enhances capabilities of all partners. This will be achieved by bringing together quality and safety, system leadership and improvement focusing on Improving Health and Care Quality and Safety through Multi-Professional Involvement and engagement (Figure 14).

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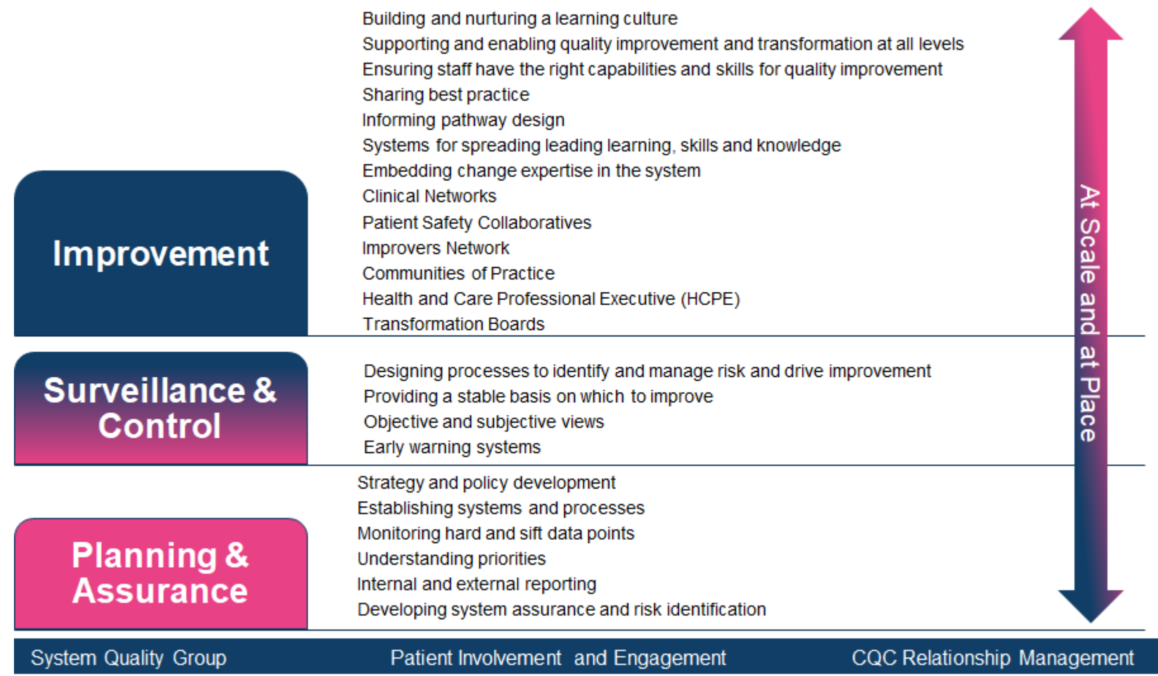

Figure 14 – transparent, continuous cyclical shared learning with work examples

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To drive the changes described in this plan, our leaders need to work across organisational boundaries at both local and county levels. Starting in East Surrey, we are pioneering a new "Growing System Leaders" programme to help key people develop their stewardship skills. We are also building maturity in how organisations shape and deliver transformation as a system, recognising the needs for more effective change capability, capacity and governance.

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By 2028 our population will benefit from:

- More staff looking after people in out of hospital settings, either at or near home
- A professionalised care workforce, with accredited skills, qualifications and better pay, terms and conditions
- More "home-grown talent", with disadvantaged job seekers provided better access to employment and more degree education provision in Surrey for professional roles.
- A corresponding investment in training, resources and awareness on Equality, Diversity and Inclusion to support and attract a diverse workforce.
- Targeted increases in roles in non-medical primary care, community nursing, diagnostics and social care
- A more mobile workforce, able to share data and work across settings.
- A "go to" digital academy for access to diverse opportunities to earn and learn across health, social care and VCSE sectors.
- Clear and accessible career structures enabling staff to have greater control over their future.
- More clinical apprenticeship and degree courses running at Surrey institutions.
- Supporting staff with better access to affordable housing and equitable, universal provision of physical and mental health services
- Many more multi-professional teams in place who are supported to collaborate, learn and improve together to consistent standards.
- United temporary staffing services across partners

- A leadership more representative of the people it serves and with the skills and tools to lead effectively across traditional boundaries.
- Trialled, researched and evaluated methods for securing the best culture to thrive.

Estates

Estates can be a catalyst for integration, particularly when approaching the delivery of neighbourhood teams and same-day urgent care. As a system, we can develop spaces and establish the conditions for communities to improve their wellbeing, on their own terms, in non-clinical ways.

The developing Surrey Heartlands and Surrey County Council Integrated Estates Strategy represents the partnership between Surrey County Council (SCC) and Surrey Heartlands Integrated Care System to re-set and re-commit to the delivery of a more efficient and effective public sector estate.

Our ambition is to make it easier to provide and support great health and social care, in the appropriate property, in the right place, fit for purpose, available at the right time and support communities and partners to deliver more effective ways of tackling health inequalities and the wider determinants of health.

CASE STUDY

WeyBetter Weybridge is a partnership Alliance - NHS Surrey Heartlands, Surrey County Council and Elmbridge Borough Council - to redevelop the healthcare and community facilities in Weybridge. The immediate priority is to build the health campus.

Future plans for the site include the redevelopment of the library and other facilities such as a community centre. The site holds many opportunities, but it is important that the plans consider all users and have the support of the site's neighbours.

Alongside the plans for community facilities, Surrey County Council is planning improvements to the town centre. The aim is to create a better town centre environment by improving pedestrian crossings and street furniture, encouraging active travel such as walking and cycling and improving traffic flow and associated air quality. The community will be involved in developing these designs.

Our population will benefit from:

By 2022/23

- A clear understanding of the health and wider public estate and opportunities.
- Developing models of delivery and a detailed programme to deliver priority schemes and pilot new ways of working.

By 2026

- Close work with community and social care services, teams, and others to identify and support delivery of priority schemes which help reduce health inequalities including supporting the creation of community diagnostic and maternity hubs.
- Delivery models for new health delivery pathways, for example, 'health on the high street'.

By 2030

- Flexible integrated health and care estate that enables the right services to be delivered and empowers communities to support each other in the places that need them.
- Estate supporting the changes in the way services are provided relieving pressure on acute settings, provide a new more agile way of working for staff, and help to reduce inequalities and improve access to the right settings across the system.

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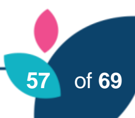

Net Zero

Surrey Heartlands' ambition is to align ICB, Acute, Mental Health and Ambulance trusts' ambitions with the wider NHS goal of becoming Net Zero Organisations. During the life of this plan, NHS England aims to reduce the emissions we control directly (the NHS Carbon Footprint) by 2040, with an **ambition to reach an 80% reduction by 2028 to 2032**.

We are looking across our estates, housing and transport programmes to progress our net zero policies across our System and Place geographies.

In our ICS Green Plan we identify the four local priorities for the NHS in Surrey Heartlands:

1. **Inhaler Project** aimed at achieving a transition of prescribing to dry powder inhalers within Acute and Primary Care resulting in reduction in emissions as well as better health outcomes (medicines optimisation).
2. **Innovation Programme** aimed at supporting innovators with implementing sustainability within their own developing programmes (innovation & research).
3. **Engagement Strategy** within the ICS and public to cultivate sentiment towards sustainability and increase understanding (working with communities).
4. **Funding support for Providers** to bid for funding for sustainability projects within their organisations.

You can read more about our sustainability work including Green Plan actions on our website and each of the NHS Trusts and Foundation Trusts have published Green Plans on their websites.

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CASE STUDY

Greener NHS - Since the launch of Ashford and St Peter's Green Plan in 2021, 80% of the vehicles in the van fleet are now electric. Food delivery miles have reduced by 20% (438 truck-miles per week). The Trust no longer uses desflurane anaesthetic, a carbon-creating gas.

Digitally Enabled Care

Our ambition is to improve how teams use and share data to create better and healthier lives empowered by digital and data. We have a vision to increase staff capacity by removing cumbersome manual administrative tasks and eliminating costs through use of automation and artificial intelligence. In this section we cover the **Digital Strategy, Data Strategy, Personal Health Record, Digital First Primary Care, Information Governance and Data Protection.**

Our **Surrey Digital and Data Strategy** is being developed by bringing together existing separate Data and Digital strategies to provide a single integrated Surrey wide strategy to help deliver better care and services to our residents now, and in the future. We have categorised 3 key categories and 7 strategic capabilities that are being delivered (Figure 15), following the NHSE design principles for the development of the digital strategy:

- Put people at the heart of everything you do
- Design for the outcome and be inclusive
- Design for context and Trust
- Test the problem and clarify assumptions
- Make, learn and iterate
- Do the hard work at the beginning to make it simple
- Make things open. It makes things better

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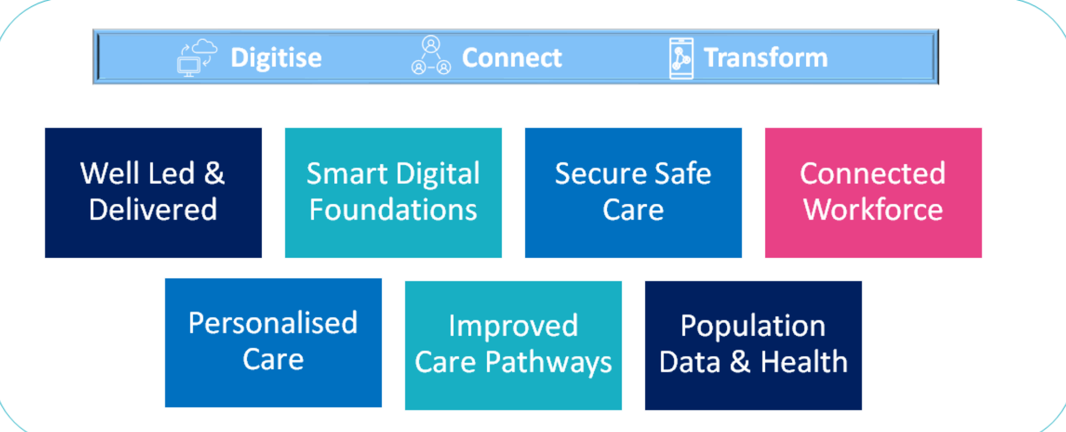

Figure 15 – Digital strategy key categories and strategic capabilities

Category 1: Digitise our services
An aligned digital and data infrastructure to create a consistent secure agile foundation for future digital transformation and tools:

- **Cyber** – A single cross organisational strategy and plan to manage cyber risk across Surrey.
- A single system wide **Data Architecture** - A shared data ecosystem (a data MESH) used for public services across health, social care and voluntary care.
- The **Integrated Digital and Data Platform** (IDDP) will meet this system integration need by providing an integrated central system, to drive Population Health Management (PHM) goals, deliver the Surrey Care Record (SCR) and Personal Health Record (PHR), a **Secure Data Environment** (SDE), Operational Planning and Reporting, including workforce, and state of the art business intelligence and advanced analytics. We expect the IDDP to go live from January 2024.
- **Surrey Care Record** - By connecting data from our many providers we can understand current and future health care needs and trends. We will also need to ensure our hard to reach populations are not digitally excluded.
- **Electronic Patient Records** - Implementation and optimisation of new EPR solutions e.g. Oracle Cerner and System 1.
- **Digitising Social Care and Care Homes** -Supporting the digitisation of 600 local health and care settings to improve citizens outcomes.

Category 2: Connect our different services and organisations
We undertook a listening project to look at ways in which digital technologies might better support patients. We spoke to patients, clinicians and the wider public to truly understand how digital technologies might support people's health needs. We particularly wanted to hear from under-represented groups and from people who do not normally use digital technologies.

- **Personalised Care** e.g. Patient Portals. Using these insights and acknowledging concerns raised during engagement sessions with citizens and staff, we are building safe and secure online access to your health records, whenever you need them and to help better manage care. Using the NHS App and healthcare provider systems people will have 24 hour access to their health care information and records to make, change or cancel appointments, check test results, contact their health and care professionals and submit test results.
- **Connecting our Workforce** - Digital Passport: Improve retention through Surrey Professional Development platform and Resilience Hub; improve recruitment through Surrey-wide temporary staffing and recruitment platforms; embed digital literacy into Core Training and focus on digital passporting.

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Category 3: Transform our current service and clinical pathways to deliver better care and outcomes

- **Elective Care** Working with colleagues to transform the Diagnostics digital capability using new technology and AI to support demand and capacity management. The creation of a single cross provider patient treatment list, implementation of improvements in theatre utilisation and prioritisation of out-patient cohorts and lists.
- **Urgent and Emergency Care** Optimisation of system control centres and further embedding the use of SHREWD - real-time operational management tools - to provide a system wide view of capacity and demand.
- **Virtual Care** Working with colleagues to support the procurement and implementation of a system wide platform to support monitoring of patients outside of hospital.
- **Digital First Primary Care** The development of digital tools to help patients easily access the care they need, such as receiving advice, booking and cancelling appointments, consulting with a healthcare professional, receiving a referral and obtaining a prescription. Expanding the capabilities most GP surgeries, hospitals, mental health services and community care services offer with video consultations, enabling contact with patients via a video call to their smartphone, tablet or computer, to talk to and see the patient.
- **Mobile first health and care applications** 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. This means that patients no longer need to visit their GP surgery or health care facility to have their readings taken. Patients will be able to submit their results via digital App, text, email or even by phone.

Not everyone wants to or can use digital technologies. However, we want everyone to have freedom of choice in accessing their care and that digital technologies complement rather than replace existing ways of working. Our **Digital Inclusion** project ensures that no one is left behind for example, we deliver digital skills training to people who have experienced domestic abuse in refugees across Surrey Heartlands and the Surrey Coalition for Disabled People project Tech to Community Connect, provides people with access to technology and advice.

We estimate that around 30% of the Surrey population do not have access to digital technologies or choose not to use them if they do. We also know that this is broadly linked to deprivation, which in turn is broadly related to poorer health outcomes.

We have created a targeted programme of action to identify those most at risk of exclusion from digital NHS services and ensure they have the support they need to access healthcare services. That means individuals being able to use computers and the internet (digital skills), being able to access to the internet (connectivity) and services designed to meet all users' needs, including those dependent on assistive technology to access digital services (accessibility).

Information governance (IG) and data protection is all about how to manage and share information safely and securely. It provides a consistent way to deal with the many different standards and legal rules that apply to information handling.

Our ambition is to create an integrated information governance function for the ICS, ensuring the safe and appropriate use of personal data on behalf of our citizens and supporting information sharing arrangements between our organisations.

Organisations within the Surrey Heartlands are now working more closely together as part of the Integrated Care System, within our Places and Primary Care Networks.

ICS, Places and PCN partner organisations need to share and use personal confidential data in order to take forward key transformational activities and achieve planned improvements in care delivery and financial efficiency. To ensure there is a protocol for these activities, the Surrey Heartlands Health and Social Care Information Sharing Agreement has been established.

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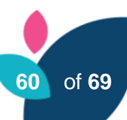

Our aim is to:

- Provide a clear framework for the secure sharing of personal confidential data for the delivery of care and for the management of the health and social care system,
- Accelerate the pace with which regional and local sharing requirements can be agreed, and
- Reduce the costs of developing and agreeing individual sharing requirements.

By 2028 our population will benefit from:

- Aligned data and digital platform to create a consistent foundation for future digital tools - simplifying access to the right information at the right time and by standardising the quality of data we will improve the available intelligence and insights for care pathway redesign, workforce prioritisation, and targeted treatment for those at high risk
- A data governance function and data management team to support the new data platform and the delivery of further integration of additional information sources, to support health and care partners deliver improved services.
- An integrated Information Governance function.
- An increase in digital capability maturity through delivery of key digital roadmap initiatives such as the Children's eRedbook (personal child health record), the Collaborative Bank (staff), Virtual Wards, Population Health Management and the Digital Social Care record.
- Access to health and care information from more partner organisations through the Surrey Care Record including Hospices and the Voluntary sector, supporting efficiencies of workflow and improvements in care transfer and delivery for better outcomes for our citizens. Implementing single-sign-on from Acute Trust electronic record systems to improve access, experience and efficiencies for health and care professionals.
- Improved quality of information held by care providers to support better care planning, decision support, improved outcomes for those in care. This will also support efficiencies in transfer of care, by assisting community and local authority partners to implement electronic records (Care homes and domiciliary) with a target of achieving 80% of providers having an electronic record by March 2024.
- Partners attaining Healthcare Information and Management Systems Society (HIMSS) level 5 Digital Maturity for comprehensive, secure electronic information available to support health and care professionals decision making, for improved patient outcomes. Acute hospitals and mental health trust by 2024(funded) with ambition of supporting Community providers to do so by 2026.
- Provision of an integrated personal health and care record, providing people of Surrey with easy access to a combined view of their health and care information held across all partner organisations from one place (NHS app). People will be able to view and change appointments, communicate with their health and care professionals and engage with their health and care plans.
- The new national Electronic Staff Record solution will be available; including increased self-service availability for managers and staff – reducing waste and improving data quality. The solution will improve our ability to ensure the right skills are built and deployed as care models improve.

You can read more about our work on the Surrey Heartlands website.

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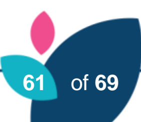
Finance

We are operating in a financial landscape that is challenged and we consider the most effective way to address these financial constraints is closer integration of health and social care as described in



this strategy, with less reliance over time on large hospitals and traditional care models, to sustainably address health inequalities and the likely needs of our population in the future.

Surrey Heartlands ICS faces a significant financial challenge. In the 2022/23, the ICS reported a deficit of (£33.6m) which represents (1.5%) of the total allocation it received for healthcare services of £2.213bn. Achievement of the deficit (£33.6m) was in part achieved using non-recurrent means - on an 'underlying' basis (excluding the impact of the non-recurrent benefits), the ICS deficit position is closer to £100m.

Recognising the extent of the underlying financial deficit in 2022, the ICS developed a five-year 'sustainability plan' which sought to both improve patient outcomes as well as place the system on a more sustainable financial footing. This work identified that without intervention and transformative re-design of services (a 'do nothing' scenario), the deficit position would deteriorate as demand for services increased a greater rate than likely available funding. Framed round the 'Critical Five' strategic objectives, a series of interventions and transformational programmes of work were developed which identified almost £100m of financial benefits over a 5 year period and which would support a balanced ICS system over time.

Work identified in the five year sustainability plan is underway. Examples include a common approach to the management of agency staff across the secondary acute system, which is starting to realise benefits and the Surrey Heartlands Elective Centre, where additional capital funding was received via a successful bid to streamline the delivery of lower complexity, higher volume surgical activity. Building on the early success of the sustainability plan work, the ICS is currently refreshing and refining its work on financial sustainability notably:

1. Extending the strategic scope of the financial plan to include SCC, recognising that the integration of services means using the aggregate available resource across all partners to the maximum benefit of the taxpayer and Surrey patients and citizens.
2. A programme of work that focusses on the interventions and service re-design that will have a short term (12-24 months) impact to try and address the immediate challenges of delivering financial balance and sustainability.

The scope of the financial plan is under development. Immediate interventions are being managed through a Delivery Oversight Group with CEO and ICS executive representation reporting to the ICS executive. Examples of programmes include:

- Leveraging the benefits of the new 'Elective Centre' at ASPH more widely across the ICS through pathway redesign which should ensure clinical interventions are delivered at the right place and at the right time;
- Continuing the commonality of approach to the management of agency and back-office resource across the system to ensure consistency and best value for money;
- Driving efficiencies on drugs procurement in both primary and secondary care designed to both improve health outcomes and reduce the overall medicines bill for the ICS; and
- Mental Health, Paediatric, Maternity and Stroke pathway optimisation across Provider organisations.

The ICS continues to work on the detail of Acute Provider Collaborative arrangements and delegations to Place, in order to support the principles of subsidiarity.

The **Better Care Fund programme** is enabling Surrey Heartlands to pool money to address the strategic ambitions of the fund. This is one financial approach we're taking to better integrate health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

The ICS submitted a breakeven income and expenditure plan for 2023/24 in line with its statutory obligation and is planning to manage its capital spend within the operating capital envelope allowable by NHSE. On an underlying basis, the ICS is a 'deficit' healthcare system – that is where

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planned expenditure is greater than planned income. Several system partners recorded deficits in 2022/23 and have submitted deficit plans for 2023/24.

It is acknowledged all partners have areas where clinical outcomes can be improved, staffing may be fragile or there is provision duplication that could be delivered collaboratively to contribute to system efficiency. Appendix 2 details productivity contributions from services featured in this Joint Forward Plan.

Like all parts of the NHS, Surrey Heartlands' procurement is subject to a number of key legislative requirements when determining the provider of a contract including the principles of transparency, equal treatment and non-discrimination. When awarding public contracts we are expected to achieve Government objectives, including value for money, maximising public benefit such as tackling climate change and integrity. The introduction of the Provider Selection Regime (PSR) requires public sector buyers to take a broad view and take account of the national strategic priorities set out in the National Procurement Policy Statement (NPPS).

Integrated Commissioning

In 2019, Surrey Heartlands made the decision to integrate commissioning across health and care; beginning with Children's services and Learning Disability & Autism, Continuing Health Care, Carers and moving to adult mental health.

Together we will continue to work in more integrated and collaborative ways for the good of the families living in Surrey. Across our system, there are several partners involved - including the local authority, health, education, the police and third sector organisations - ensuring that in Surrey people are safe, healthy and can live up to their potential.

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Our programme of work aims to:

- **Re-affirm the vision and ambition for integrated commissioning** – re-committing to and further defining integrated commissioning in Surrey as essential to ensuring good outcomes for residents/patients and value for money.
- **Re-affirm a target operating model for integrated commissioning** – understanding the gap between the ambition and the current situation to develop, design and implement improvements. This will include around governance, working practices, culture, infrastructure such as IT and building space etc.
- **Improve joint-planning** – ensuring a better understanding of existing organisation plans and planning cycles and enable greater joint-planning both in the short and long term.
- **Identify initial areas of commissioning/contracts where we can improve our integrated working** – understanding what opportunities we have coming up within our commissioning forward plan to improve our integrated commissioning practice (using the target operating model) and improve outcomes and value for money for residents and patients.
- **Ensure commissioners are supported to do good integrated commissioning** – through a learning, development and networking programme.

CASE STUDY

Our Joint Commissioning Strategy for Children and Young People highlights good areas of effective joint commissioning including – the HOPE and crisis intensive support services, Mindworks and community health contracts.

Governance and System Working

As a mature ICS, Surrey Heartlands is already achieving aspects of thriving system working. At the same time, it's clear the scale of the challenges we face, alongside our wider ambitions, mean we will need to work very differently over the next few years if we are going to get services back to where our communities want and need them to be, and create the step-change we want to see for our population.

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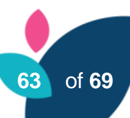

Working as a system we can accelerate improvement and innovation to ensure investment and support is targeted where it will have the greatest impact. Developing the principle of subsidiarity is our ambition through the delivery of our ICS strategy. Strengthening local leadership, supported by continuous quality improvement and a commitment to sustainable primary care provision is at the heart of our approach to governance.

We will continue to develop informed decision making through the incorporation of expert advice such as the Primary Care Advisory Forum and Health Care Professional Executive - and broader engagement including people and communities.

You can find our more information about our board meetings, board members, committees and governance on the Surrey Heartlands website and appendix 1.

System Led Assurance

Assurance and performance monitoring is enacted through a wide range of tools and assurance reports, underpinned by the NHS Oversight Framework (OF) – a national framework with local flexibility encompassing NHS priorities and operational planning and NHS Long Term Plan delivery commitments. Assurance arrangements are set out within a Memorandum of Understanding (MoU) at ICS, Place, and organisational performance delivery level. To support this, review meetings are undertaken as follows:

- ICS Review Meetings: led by NHSE regional team with the ICS Leadership Team, system partner CEOs and AO and commissioners on a quarterly basis.
- Place Review Meetings: obtained through existing local governance arrangements for the four place-based partnerships, which continue to evolve. Led by the ICS with provider and commissioner leadership team and Place Based Leaders as appropriate. The frequency of meetings to be determined in discussion between NHSE regional team and the ICS.
- Individual organisations/collaboratives: led by NHSE, ICS and organisational teams as relevant for cross ICS, provider collaborative and exceptional meetings. This includes the bi-monthly SECAmb System Assurance Meetings jointly held by the ICS and NHSE.

The Assurance, Performance and Quality Teams work together to ensure the inter-dependencies with Quality Assurance are integral to the ICS-led assurance processes. You can read more about the metrics and monitoring used to assure our delivery in appendix 3.

Innovation and Research

Through our Innovation strategy, Surrey Heartlands aims to establish itself as a dynamic health and care ecosystem and the destination of choice to trial and scale the latest local, national, and international health and care research and innovations. Through collaborations and partnerships that leverage knowledge and expertise across Industry, Academia and Health and Care, we can look to drive exploratory innovation to address unmet needs whilst identifying and implementing those that will deliver the most impact at scale.

With the support of the Allied Health Science Network (AHSN) and wider system partners, our Innovation Strategy aims to establish us as a dynamic health & care system and the destination of choice to trial and scale research and innovation. It has four objectives aligned to the NHS Long Term Plan to drive future outcomes improvement through enabling prevention of ill-health, earlier diagnosis, better outcomes, and faster recovery and increasing the number of people participating in health research and accelerating development of innovations:

1. Create, manage, and deliver an effective innovation pipeline prioritised to the needs of the citizens of Surrey Heartlands
2. Create an internal operating model and methodology to deliver maximum benefits to Surrey ICS

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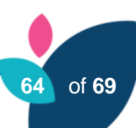

3. Develop a strategy to attract industry investment and leverage additional capabilities to support delivery and development of novel solutions
4. Develop a Research Strategy to advocate & establish a mechanism for Research to be scaled at a system level and embedded into "care as usual"

This will be achieved through the adoption of an influencing model that enables the ICS innovation function to offer services across neighbourhood, place & system. We will cultivate a culture that allows people within and across multiple organisations to co-create, develop, and test new ideas and facilitate turning those ideas into business value. Our focus will be on guiding the Innovation Strategy at a system level and with the support of the AHSN and wider system partners, we will:

- Convene and support providers to implement innovation aligned with Core20Plus5, the Health and Wellbeing Strategy, the 'Critical 5' and the Fuller Stocktake
- Promote innovation, from the development of new ideas to spread through all areas of the system
- Develop a workforce culture, supporting entrepreneurs and embedding innovation into practice
- Enable economic growth through the development and adoption of innovation across Surrey Heartlands

By 2028 our population will benefit from:

- Greater use of innovation – for example, to support self-management for citizens
- Reductions in unwarranted variation in the provision of care when this is needed
- Greater economic growth – jobs and investment measurably leveraged into the local system

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Glossary

Acronym	Description	Acronym	Description	Acronym	Description
3TT	Three Treatment Targets	FH	Familial Hypercholesterolaemia	PCN	Primary Care Network
8NCP	Eight NICE Care Processes	GP	General Practitioner	PHB	Personal Health Budget
A&E	Accident & Emergency	GPIMHS	General Practice Integrated Mental Health Services	PHM	Population Health Management
A&G	Advice and Guidance	HCAI	Healthcare Associated Infections	PHR	Personal Health Record
AF	Atrial Fibrillation	HIMSS	Healthcare Information and Management Systems Society	PIFU	Patient Initiated Follow Up
AO	Accountable Officer	HSJ	Health Serviced Journal	POD	Point Of Delivery
AOMRC	Academy of Medical Royal Colleges	ICB	Integrated Care Board	PSR	Provider Selection Regime
ARI	Acute Respiratory Infection	ICP	Integrated Care Partnership	PTSD	Post Traumatic Stress Disorder
ASH	Action on Smoking and Health	ICS	Integrated Care System	QIC	Quality Improvement Collaborative
ASHN	Allied Science Health Network	ICSS	Integrated Community Stroke Service	RSFT	Royal Surrey Hospital
BAME	Black and Minority Ethnic	IDDP	Integrated Digital and Data Platform	SABP	Surrey and Borders Partnership NHS Trust
BSI	Blood Stream Infections	IG	Information Governance	SASH	Surrey and Sussex Healthcare NHS Trust
CAMHS	Child And Adolescent Mental Health Services	INT	Integrated Neighbourhood Teams	SCAS	South Central Ambulance Service
CEO	Chief Executive Officer	ISDN	Integrated Stroke Delivery Networks	SCC	Surrey County Council
CHC	Continuing Health Care	JFP	Joint Forward Plan	SCR	Surrey Care Record
CMHT	Community and Mental Health Transformation	LDA	Learning Disabilities and Autism	SDE	Secure Data Environment
COPD	Chronic obstructive pulmonary disease	LHRP	Local Health Resilience Partnerships	SDEC	Same Day Emergency Care
CPCS	Community Pharmacy Consultation Service	LTP	Long Term Plan	SECAMB	South East Coast Ambulance
CPR	Cardiopulmonary Resuscitation	LVAD	Left Ventricular Assist Device	SEND	Special Educational Needs And Disability
CQUIN	Commissioning For Quality And Innovation	MEDSIP	Medicines Safety Improvement Programme	SGO	Special Guardian Order
CVD	Cardio Vascular Disease	MOU	Memorandum Of Understanding	SQP	System Quality Group
CYP	Children And Young People	MVP	Medicines Value Programme	SSNAP	Sentinel Stroke National Audit Programme
DA	Domestic Abuse	NDH	Non-Diabetic Hyperglycaemia	UCR	Urgent Community Response
EDI	Equality, Diversity and Inclusion	NDPP	National Diabetes Prevention Programme	UK	United Kingdom
EPR	Electronic Patient Record	NHSE	NHS England	VCSE	Voluntary, Community and Social Enterprise
ERF	Elective Recovery Fund	NNPS	National Procurement Policy Statement	WDES	Workforce Disability Equality Standards
EWMH	Emotional Wellbeing And Mental Health	NOSIP	National Optimal Stroke Imaging Pathway	WHO	World Health Organisation
FDS	Faster Diagnosis Standard	OF	Oversight Framework	WRES	Workforce Race Equality Standards

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References

A guide to community-centred approaches for health and wellbeing
A plan for digital health and social care
Adult Social Care Strategy for people with Physical Disability and Sensory Impairment (PDSI) 2022 to 2027
All Age Autism Strategy
All our Health - about the framework (gov.uk website)
Ashford & St Peters NHSFT Green Plan Jul 2022
Ashford & St Peters NHSFT Strategy 2018-2023
B1269-elective-recovery-planning-supporting-guidance.pdf (england.nhs.uk)
B1378_NHS-Oversight-Framework-22-23_260722.pdf (england.nhs.uk)
B1940-guidance-on-developing-the-joint-forward-plan-december-2022
Better Births (2016); the Maternity Incentive Scheme (NHSR)
Better Care Fund Planning requirements 2023-2025 (NHSE, April 23)
Building the Right Support Action plan 2022
Choice in mental health - choice-in-mental-health-care-v5.pdf (england.nhs.uk)
Climate Change Delivery Plan Main Report (PDF)
CSH Green Plan (cshsurrey.co.uk)
Data saves lives
Delivering a 'Net Zero' National Health Service (NHSE)
Delivering a quality public health function in integrated care boards, NHS England
Down Syndrome Act 2022
End of Life Care - ICS (surreyheartlands.org)
Epsom and St Helier University Hospitals Strategy 2020 - 2025
Equality, diversity and inclusion action plan 2022 to 2023 - Surrey County Council
from-harm-to-hope
Going further on our winter resilience plans (NHSE website)
GP Patient Survey 2022 National report (local save)
Greener Future Climate Change Delivery Plan (SCC)
Guidance on the legal rights to have personal health budgets and personal wheelchair budgets
Health and Social Care Act 2008: code of practice on the prevention and control of infections
Health disparities and health inequalities: applying All Our Health (gov.uk website)
Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk)
Homelessness - Elmbridge Borough Council - Housing strategies and policies
Homelessness | Epsom and Ewell Borough Council (epsom-ewell.gov.uk)
Homelessness and Rough Sleeping Strategy.pdf (spelthorne.gov.uk)
Homelessness Mole Valley District Council Homelessness Strategy
Homelessness Runnymede Homelessness Strategy 2019-24
Homelessness Strategy 2018 - 2023 Woking (woking.gov.uk)
Homelessness Strategy 2018-23 and Action Plan.pdf (waverley.gov.uk)
Homelessness Strategy 2022 to 2027 | Housing strategies | Reigate and Banstead (reigate-banstead.gov.uk)
Homelessness Strategy Guildford Borough Council (guildford.gov.uk)
Hospital Discharge and Community Support Guidance (pending 21/11/22)
Housing, Homelessness and Rough Sleeping Strategy 2021 - 2026 (tunbridgewells.gov.uk)
Housing Strategy Survey - Surrey County Council

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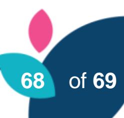
11

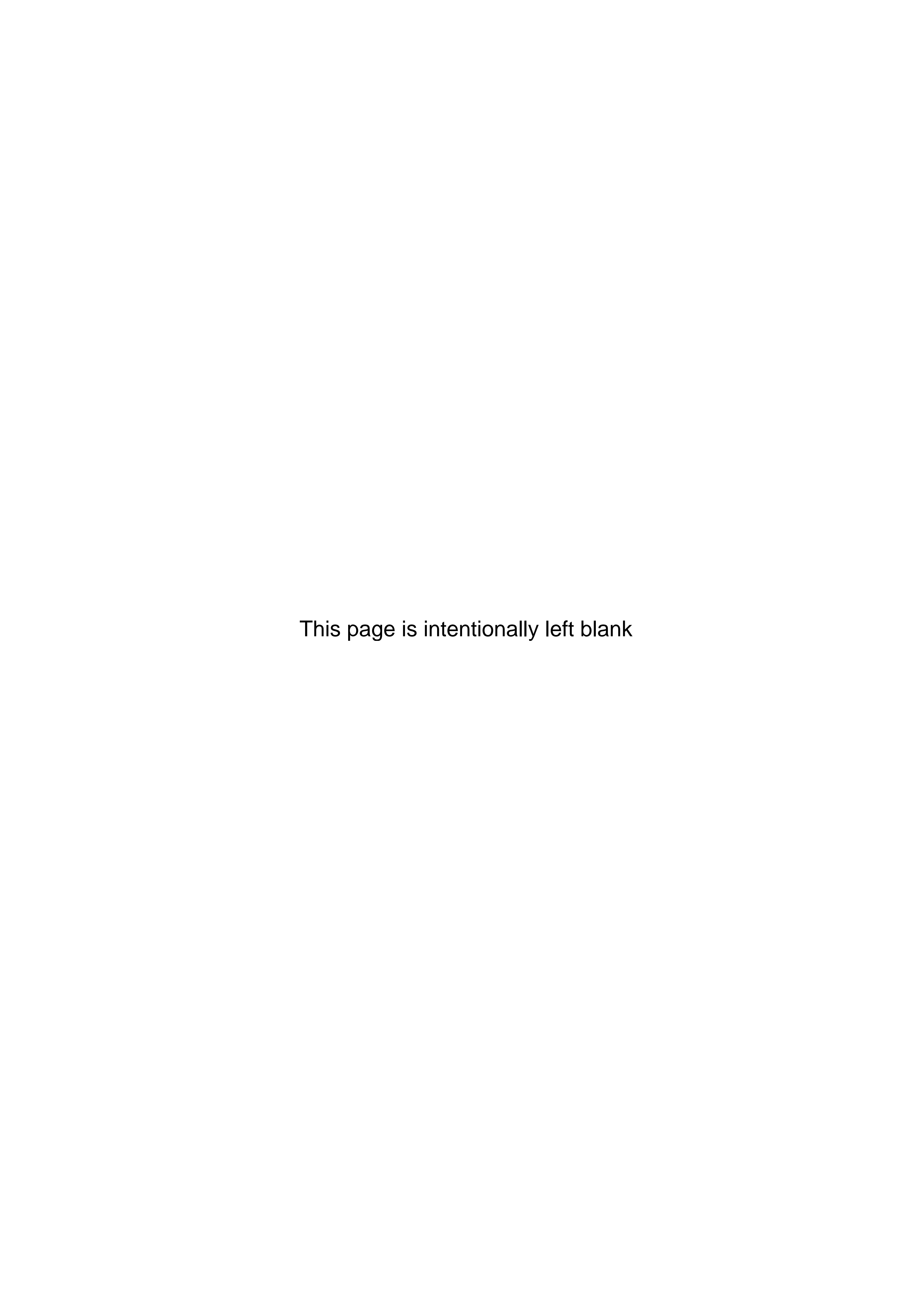
How to produce a green plan: a 3 year strategy towards net zero
Domestic_Abuse_Act_2021_Statutory_Guidance
Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk) (gov.uk website)
Integrated care strategy
Integrated Health and Social Care for people experiencing homelessness
Joining up care for people, places and populations
Joint Health and Social Care Dementia Strategy for Surrey 2022-2027 (PDF)
Joint local health and wellbeing strategies
Joint strategic needs assessments
JSNAs and JHWS statutory guidance (updated 24 Aug 22)
LDA - Building the right support
LDA Three year delivery plan
Levelling Up the United Kingdom: Executive Summary (publishing.service.gov.uk)
Living Well in Later Life Strategy 2021 – 2030 Commissioning Strategy for Older People (SCC Nov 21)
Maternity and neonatal services in East Kent: 'Reading the signals' report (gov.uk website)
MBRRACE-UK_Perinatal_Surveillance_Report_2020
Mental Health of Children and Young People in England 2022 -NHS Digital
Movement for Change
National Health Service Act 2006 (legislation.gov.uk)
National strategy for autistic children, young people and adults
Net Zero - NHS Clinical Waste Strategy
NHS Mandate 2022-2023
NHS England » Delivery plan for recovering access to primary care
NHS England - ICS Guidance on Maximising the Benefits of Research
NHS England » 202023/24 priorities and operational planning guidance
NHS England » Guidance on developing the joint forward plan
NHS England » Health and justice framework for integration 2022-2025
NHS England » Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme
NHS England » NHS delivery and continuous improvement review: recommendations
NHS England » NHS Diabetes Prevention Programme (NHS DPP)
NHS England » The Healthcare Inequalities Improvement Dashboard
NHS England » Working in partnership with people and communities: Statutory guidance
NHS Long Term Plan
NHS Oversight Framework metrics 22/23 Report template - NHSI website (england.nhs.uk)
Older People's Commissioning Strategy 2021 - 2030 (PDF)
Older Peoples Commissioning Strategy 2021-2030
One Public Estate (Local Government Association)
Our plan for patients - GOV.UK (www.gov.uk) (Sep 22)
Our strategy for young carers - Action for Carers
Palliative & End of Life Care Strategy 2020-2025
People at the Heart of Care: adult social care reform white paper
PHE Strategy 2020-2025
Police and Crime Plan Office of the Police and Crime Commissioner for Surrey
Promoting the health and wellbeing of looked after children (updated 24 Aug 22)
Public Health Outcomes Framework 2019 to 2020: a consultation (publishing.service.gov.uk)
Public Health Service Plan 2022-23 (surreycc.gov.uk)

FINAL DRAFT



Royal Surrey NHSFT - Green Plan 2020 -2024
Royal Surrey NHSFT Strategy 2022-2025
Saving Lives, Improving Mothers' Care (MBRRACE 2021)
Securing meaningful choice for patients - choice-planning-guidance.pdf (england.nhs.uk)
South East Coast Ambulance NHSFT Improvement Journey Autumn 2022
South East Coast Ambulance NHSFT Strategy 2020
South East Coast Ambulance NHSFT Green-Strategy-2022-2025
Strategic_Plan_2014-15.pdf (sabp.nhs.uk)
Sufficiency Strategy 2020- 2025 for looked after children (PDF)
Surrey & Sussex Healthcare NHS Trust Operating Plan 2022_23
Surrey Adult Safeguarding Board Strategy 2022-2025
Surrey Against Domestic Abuse Strategy
Surrey and Borders Partnership NHST Green Plan 2020-2025
Surrey And Sussex Healthcare Trust Green Plan 2022
Surrey Carers Strategy
Surrey Community Safety Agreement 2021 - 2025 (PDF)
Surrey Economic Strategy Statement
Surrey Health and Wellbeing Strategy – original approach & methodology
Surrey Heartlands Data Strategy (2022)
Surrey Heartlands GP Patient Survey 2022 report (local save)
Surrey Heartlands Green Plan
Surrey Heartlands Population Health Summit 2023
Surrey Inclusion and Additional Needs Partnership Strategy (2023 to 2026)
Surrey Learning Disability and Autism Action Plan (2021-2024)
Surrey SEND Partnership strategy 2019 - 2022
Surrey Substance Misuse Strategy Alcohol Section Refreshed April 2019
Surrey Tobacco Control Strategy: Smokefree Surrey 2016 2021
Surrey young carers strategy – to add
Surrey's Climate Change strategy (PDF)
Surrey Heartlands System Development Plan 2022
Technical report on the COVID-19 pandemic in the UK - GOV.UK (www.gov.uk)
The Climate Change Act 2008
The Hewitt Review: an independent review of integrated care systems (publishing.service.gov.uk)
The Independent Review of Maternity Services (Ockenden,2022)
The Maternity Transformation Programme (NHSE).
The Public Health Approach to Serious Youth Violence
Three-year-delivery-plan-for-maternity-and-neonatal-services (March 2023)
Tobacco control plan: delivery plan 2017 to 2022 (DHSC)
uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024
NHS Urgent and Emergency Care Delivery Plan
What Good Looks Like framework (digital) - NHS Transformation Directorate (england.nhs.uk)
Who I am Matters – experiences of being in hospital for people with a learning disability and autistic people (cqc.org.uk) (Nov22)
Winter Resilience Plan 22/23
Women's Health Strategy for England (August 2022)
Working in Partnership with People and Communities (england.nhs.uk)

FINAL DRAFT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