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SURREY HEARTLANDS JOINT FORWARD PLAN

2023 to 2028

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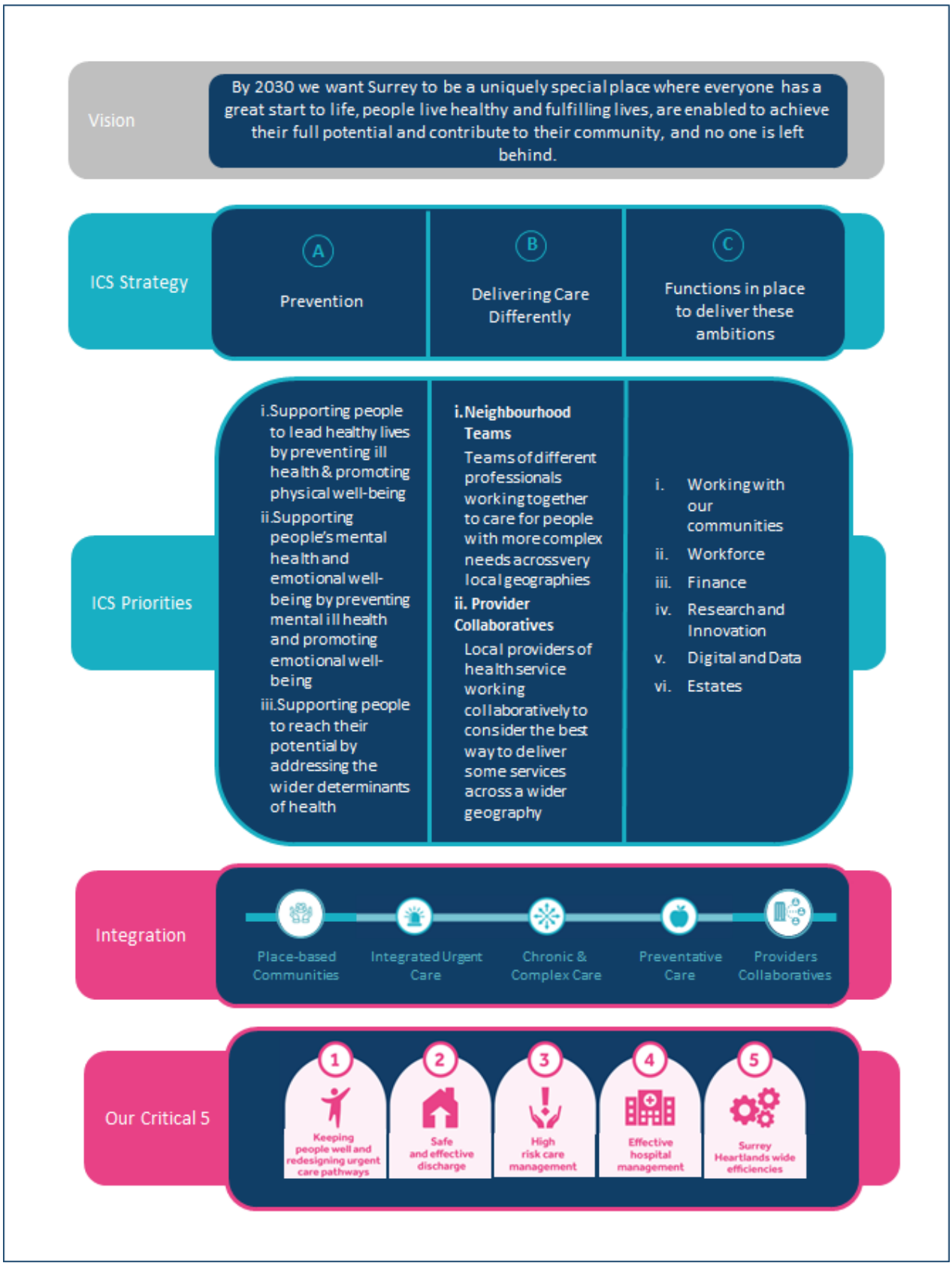
One System, One Plan



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.

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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.

1. Prevention
2. Delivering Care Differently
3. What we need to deliver these ambitions

This our second 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 **the first two years** of our strategy.

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

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

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

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

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

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

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

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

These strategic ambitions are a key part of our One System, One Plan framework – a single view of transformation and recovery which is reflected in the plans and strategies of all partners. Embedded within these is the vision from the 'Next steps for integrating primary care: 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.

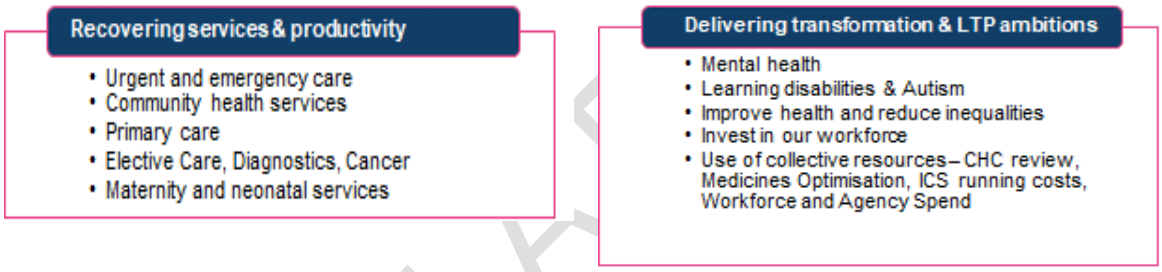
Our Trust Provider Collaborative, was formally established in summer 2023, working together, as experts in service delivery, to address immediate challenges and deliver longer-term service transformation to ensure future quality, workforce and financial sustainability.

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, general medical practice and general dental 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 continue to deliver against the national NHS priorities:



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 the four pillars of primary care services**; bringing together general medical practice, community pharmacy, general dental care services 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. Therefore, the first two years of the plan contain 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.

- **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.
- **Service recovery**– high volumes of planned and emergency care, including delays in care and presentation continue following the pandemic and significant industrial action by clinicians during 2023 and early 2024.
- **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** adds further hurdles to building an effective workforce supply.
- **Running cost reductions** – achieving success while streamlining workforce and other costs.
- **System Flow** – high levels of demand and reduced capacity in care settings and effective discharge result in longer patient journeys through our system and challenging environments for our workforce.
- **System maturity** – whilst we have good relationships across our partners, and bold ambitions, we have variable maturity in how we work together to transform, integrate and manage our services day to day.
- **Addressing access and continuity of care** – we continue to see service users experiencing challenges and delays in accessing some services and fragmented care.

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.

Building on our success

We have seen many improvements and achievements in year one of this Joint Forward Plan, despite the challenges of the pandemic recovery, industrial action by clinicians and financial constraints.

- **Prevention** - A range of projects are being delivered through the No One Left Behind Skills and Employment Network to provide targeted support those furthest from employment and Local Area Coordinators are active in a number of Key Neighbourhoods
- **Keeping well** - Short term extension of Changing Futures funding until 2025 allowing further delivering and good outcomes being delivered for those experiencing multiple disadvantage
- **Aging well** – Neighbourhood teams have developed further support for people living with frailty, ensuring those who are ageing and living with long term conditions have a Personalised Care Plan based on what is important to them utilising the wider community assets.
- **Primary Care access** - Patients can submit online requests to 97% of our GP surgeries via the NHS App
- **Carers** - In 2023/24 the number of carers assessments completed by Surrey County Council has increased by 29%, carers support plans created increased by 40% and carers support plans revies increased by 23%.
- **Children and young people** - Growth of voluntary sector support for children's emotional wellbeing and mental health including to Young Carers and new crisis care support pilot for children with a learning disability or autism
- **Cardiovascular Disease** - Learning from our system partner's Healthy Heart Project (which was part of wider NHS Health Checks service commissioned and led by Public Health), an outreach project delivering free blood pressure and atrial fibrillation checks for those aged 35+ and no known CVD diagnosis
- **Diabetes** - Increased referrals and uptake in NHS Diabetes Prevention Programme.
- **Developing fulling careers** – 38 prospective volunteers have started our volunteer training programme, 41 international Allied Health Care Professionals have been recruited and 6 new candidates have started the nursing associate training programme for developing community nursing.
- **Quality of care** - Continued improvements for all our providers who require support to achieve regulatory assurance.

Using our collective strengths and assets, we will measure success through our achievements, performance measures, plus patient and user experience. This Joint Forward Plan (JFP) sets out how we will deliver our strategic ambitions by 2028:

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