

ICB and System Change

July 2026

Executive summary (1/2)

As we begin a new financial year, we have the opportunity to make real change across the NHS in Surrey and Sussex – building on the progress over recent years, addressing the existing challenges, and delivering on our collective ambition for improved outcomes and value.

- We know that Surrey and Sussex face rising demand, worsening inequalities, and increasing multimorbidity, with preventable ill health driving unsustainable activity and cost pressures.
- The next decade will see significant growth in complex need, concentrated disproportionately in deprived communities. Without intervention, these trends will deepen health inequalities and increase the financial deficit to over £0.5bn by 2035/36.
- ‘Do Nothing’ is not an option - the scale of challenge requires coordinated action across the system.

Executive summary (2/2)

- We all need to make a deliberate left shift – neighbourhood health at the core, with work to address the front and back doors of acutes and transform across pathways, for improved outcomes and value.
- The new Surrey and Sussex Five Year Plan helps articulate our ambition and areas of opportunity, and the transition of the ICB to strategic commissioning will also enable a collective focus on population health, outcomes, and shared delivery....but it will take conscious effort from all partners.
- There will need to be collective expectations, shared goals and deliverables, and a collective approach to risk across partners.



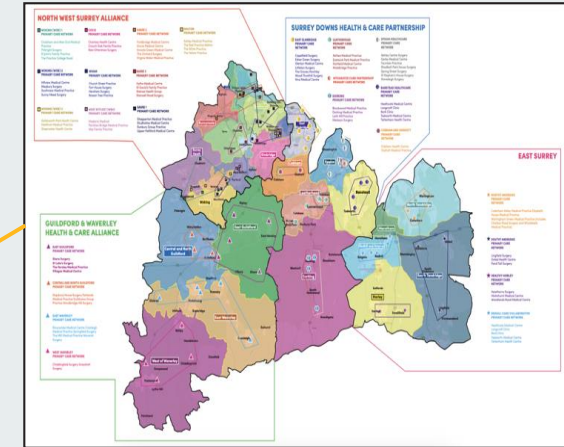
Activity linked to higher-needs cohorts (2/2)

- Around 16% of the Surrey and Sussex population accounts for nearly 75% of health and care spend.
- People living with three or more long-term conditions account for approximately:
 - **40% of nonelective hospital spells**
 - **60% of nonelective bed days**

- Without intervention, the most complex cohorts will account for more than 80% of total expenditure within the next decade.
- Understanding and proactively supporting this group is essential for improving outcomes and ensuring system sustainability.

Neighbourhood health at our core

- The NHS is constantly publishing plans (5 Year Forward View (2014), the NHS Long Term Plan (2019), etc.) but very little ever changes: we need to understand the reasons why and make it different this time.
- Neighbourhood health sits at the heart of the 10 Year Health Plan and our Surrey and Sussex strategies.
- We are building an integrated, multi-disciplinary service that delivers more personalised care closer to where people live; empowers people to lead healthier, more independent lives; and offers genuine choice in how people access support.
- We are working across place (local authority footprints) and neighbourhoods (footprints of about 50,000 people), through our integrated neighbourhood teams (INTs) – currently 44 across Surrey and Sussex.
- Health and Wellbeing Boards (HWBs) will be the major engine to drive more integrated care and for local government to address the wider determinants of health



Surrey and Sussex



Population health approach

Population Health Management (PHM) is central to neighbourhood delivery and underpins a more proactive approach to supporting people with complex needs.

In developing our plan, we have used this approach.

Population health strategic commissioning functions ensure that data, insight and evidence are translated into targeted, equitable and value-based service decisions by systematically assessing need, segmenting populations, prioritising resources, redesigning pathways, implementing change, and continuously evaluating impact to improve outcomes and reduce inequalities.

By strengthening our use of data insights, integrated neighbourhood teams are able to proactively identify and prioritise need across our populations, enabling more targeted, preventative and coordinated support.

PHM in Neighbourhoods	Step up approach to risk stratification	Invest in tools skills and capabilities	Population Health Improvement
	Focus • A consistent approach to identifying and prioritising population need. • Use data to understand rising risk, complexity and opportunity for early intervention. • Support neighbourhoods and Places to segment populations in ways that inform action	Focus • Invest in PHM tools that support risk stratification and population segmentation. • Support teams to use PHM data confidently in day-to-day clinical and operational decisions. • Ensure insights are timely, usable and embedded into neighbourhood delivery.	Focus • Support a learning-based approach to improvement supported by data. • Support neighbourhoods to plan, test and refine interventions over time. • Embed tracking of outcomes to measure to citizens and populations
	What this enables • Shared understanding of priority cohorts across neighbourhoods and Places. • More proactive and preventative neighbourhood-based care. • Stronger alignment between neighbourhood delivery, Place planning and system priorities.	What this enables • Teams able to translate data and insight into practical action. • More consistent use of PHM across neighbourhoods and Places. • Improved decision-making grounded in evidence rather than activity alone.	What this enables • Continuous improvement rather than one off initiatives. • Shared learning across neighbourhoods and Places. • Clear line of sight between activity, outcomes and impact.

In conclusion

- Despite the hard work of clinicians and carers, the system produces relatively poor patient outcomes at a high cost to taxpayers.
- Through the ICB transition, we will focus on our role and core purpose: to use 'strategic commissioning' to drive the three left shifts, especially hospital to community and sickness to prevention.
- Provider collaboration is key – and service challenges cannot be solved by individual organisations alone
- 'Do Nothing' is not an option...the three shifts are not optional...without intervention there will be further demand and further financial challenges...and we will not improve the health of our people and residents.