Notice of Meeting

Health and Wellbeing Board

Date & time	Place	Contact
Thursday, 6 June 2019 at **1.00 pm**	Ashcombe Suite, County Hall, Penrhyn Road, Kingston upon Thames KT1 2DN	Ben Cullimore Room 122, County Hall Tel 020 8213 2782 ben.cullimore@surreycc.gov.uk

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This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Ben Cullimore on 020 8213 2782.

Board Members

Helen Atkinson	Executive Director of Public Health and Wider Determinants of Health
Dr Andy Brooks	Chief Officer, Surrey Heath and East Berkshire Clinical Commissioning Group
Dr Charlotte Canniff	Clinical Chair, North West Surrey Clinical Commissioning Group
Dave Hill	Executive Director for Children, Families and Learning
Jason Gaskell	CEO, Surrey Community Action
Dr Russell Hills	Clinical Chair, Surrey Downs Clinical Commissioning Group
David Munro	Police and Crime Commissioner
Mr Tim Oliver (Chairman)	Leader of the Council
Kate Scribbins	Chief Executive, Healthwatch Surrey
Dr Elango Vijaykumar (Deputy Chairman)	Clinical Chair, East Surrey Clinical Commissioning Group
Simon White	Executive Director of Adult Social Care
Dr Claire Fuller	Senior Responsible Officer, Surrey Heartlands
Fiona Edwards	Chief Executive, Surrey and Borders Partnership
Joanna Killian	Chief Executive, Surrey County Council
Helen Griffiths	Executive Dean of the Faculty of Health and Medical Sciences, University of Surrey
Sue Littlemore	Head of Partnerships and Higher Education, Enterprise M3
Mrs Sinead Mooney	Cabinet Member for Adults and Public Health
Mrs Mary Lewis	Cabinet Member for Children, Young People and Families
Ruth Colburn Jackson	Managing Director, North East Hampshire and

	Farnham Clinical Commissioning Group
Giles Mahoney	Director of Integrated Care Partnerships, Guildford and Waverley Clinical Commissioning Group
Siobhan Kennedy	Housing Advice Manager, Guildford Borough Council
Rob Moran	Chief Executive, Elmbridge Borough Council
Rod Brown	Head of Housing and Community, Epsom and Ewell District Council

TERMS OF REFERENCE

The Health and Wellbeing Board:

- oversees the production of the Joint Health & Wellbeing Strategy for Surrey;
- oversees the Joint Strategic Need Assessment; and
- encourages integrated working.

PART 1
IN PUBLIC

1 APOLOGIES FOR ABSENCE

To receive any apologies for absence and substitutions.

2 DECLARATIONS OF INTEREST

All Members present are required to declare, at this point in the meeting or as soon as possible thereafter

(i) Any disclosable pecuniary interests and / or
(ii) Other interests arising under the Code of Conduct in respect of any item(s) of business being considered at this meeting

NOTES:

- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest
- As well as an interest of the Member, this includes any interest, of which the Member is aware, that relates to the Member's spouse or civil partner (or any person with whom the Member is living as a spouse or civil partner)
- Members with a significant personal interest may participate in the discussion and vote on that matter unless that interest could be reasonably regarded as prejudicial.

3 MINUTES OF PREVIOUS MEETING: 4 APRIL 2019 (Pages 1 - 4)

To agree the minutes of the previous meeting.

4 QUESTIONS AND PETITIONS

a Members' Questions

The deadline for Members' questions is 12pm four working days before the meeting (31 May 2019).

b Public Questions

The deadline for public questions is seven days before the meeting (30 May 2019).

c Petitions

The deadline for petitions was 14 days before the meeting and none have been received.

5 IMPROVING HEALTHCARE TOGETHER 2020-2030 (Pages 5 - 12)

The Improving Healthcare Together (IHT) 2020-2030 programme is led by experienced GPs from NHS Surrey Downs, Sutton and Merton Clinical Commissioning Groups (CCGs).

We are working with Epsom and St Helier University Hospitals NHS Trust

(ESTH) to address a series of long-standing challenges and improve healthcare for local people in the future.

This reports outlines the progress to date with the programme of work and the next steps prior to any potential public consultation.

6 END OF LIFE CARE PARTNERSHIP PROJECT (Pages 13 - 18)

The Health and Wellbeing Strategy identified 'helping people in Surrey to lead healthy lives' as one of three interconnected priorities for partners to work together to improve outcomes across the county. An agreed key focus area within this was to help people to live independently for as long as possible and to die well. The Health and Wellbeing Board has asked officers to scope out partnership opportunities to support work around End of Life Care.

This paper sets out the current picture of End of Life Care commissioning priorities in Surrey, to enable the Board to scope a partnership project aimed at delivering an equitable, high quality End of Life Care service – to ensure Surrey residents and their families are able to access the care they need, as well as die with dignity in their preferred setting.

7 PRIORITY ONE DRAFT IMPLEMENTATION PLAN (Pages 19 - 30)

This paper introduces the draft implementation plan for 'Priority One: Helping people to live healthy lives'. Following approval, we will begin engagement on the draft implementation plan with key stakeholders and partnerships.

The Surrey Prevention and Wider Determinants of Health will sign off the final implementation plan in the autumn before the implementation plan is brought to the Health and Wellbeing Board for approval in December.

8 DEVELOPING THE COMMUNITY DEVELOPMENT SYSTEM CAPABILITY (Pages 31 - 36)

Community development is identified as a system capability in order to deliver the Health and Wellbeing Strategy and the 2030 Community Vision for Surrey.

The Health and Wellbeing Strategy proposes developing a community development workstream and a community engagement plan.

9 DATE OF THE NEXT MEETING

The next public meeting of the Health and Wellbeing Board will be on 5 September 2019.

Joanna Killian
Chief Executive
Surrey County Council
Published: Wednesday, 29 May 2019

QUESTIONS, PETITIONS AND PROCEDURAL MATTERS

The Health and Wellbeing Board will consider questions submitted by Members of the Council, members of the public who are electors of the Surrey County Council area and petitions containing 100 or more signatures relating to a matter within its terms of reference, in line with the procedures set out in Surrey County Council's Constitution.

Please note:

1. Members of the public can submit one written question to the meeting. Questions should relate to general policy and not to detail. Questions are asked and answered in public and so cannot relate to "confidential" or "exempt" matters (for example, personal or financial details of an individual – for further advice please contact the committee manager listed on the front page of this agenda).
   The Public engagement session held at the end of the meeting is made available to Members of the public wanting to ask a question relating to an Item on the current agenda. Questions not relating to items on the agenda will need to be submitted in advance of the meeting.
2. The number of public questions which can be asked at a meeting may not exceed six. Questions which are received after the first six will be held over to the following meeting or dealt with in writing at the Chairman's discretion.
3. Questions will be taken in the order in which they are received.
4. Questions will be asked and answered without discussion. The Chairman or Board Members may decline to answer a question, provide a written reply or nominate another Member to answer the question.
5. Following the initial reply, one supplementary question may be asked by the questioner. The Chairman or Board Members may decline to answer a supplementary question.

MOBILE TECHNOLOGY AND FILMING – ACCEPTABLE USE

Those attending for the purpose of reporting on the meeting may use social media or mobile devices in silent mode to send electronic messages about the progress of the public parts of the meeting. To support this, County Hall has wifi available for visitors – please ask at reception for details.

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It is requested that if you are not using your mobile device for any of the activities outlined above, it be switched off or placed in silent mode during the meeting to prevent interruptions and interference with PA and Induction Loop systems.

Thank you for your co-operation.

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MINUTES of the meeting of the **HEALTH AND WELLBEING BOARD** held at 1.00 pm on 4 April 2019 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Board at its meeting on Thursday, 6 June 2019.

Elected Members:

* Helen Atkinson
* Dr Andy Brooks
* Dr Charlotte Canniff
  Dave Hill
* Jason Gaskell
* Dr Russell Hills
* District Councillor Vivienne Michael
* David Munro
* Mr Tim Oliver (Chairman)
* Kate Scribbins
* Borough Councillor Paul Spooner
* Dr Elango Vijaykumar (Deputy Chairman)
* Simon White
* Dr Claire Fuller
* Fiona Edwards
* Joanna Killian
* Helen Griffiths
  Sue Littlemore
* Mrs Sinead Mooney
* Mrs Mary Lewis
  Ruth Colburn Jackson
* Giles Mahoney
  Catherine Butler
  Rob Moran
* Rod Brown

Substitute Members:

Patricia Denney

12/19 APOLOGIES FOR ABSENCE [Item 1]

Apologies were received from Ruth Colburn Jackson, Dave Hill, Helen Griffiths, Siobhan Kennedy and Sue Littlemore.

Dr Andy Brooks acted as a substitute for Ruth Colburn Jackson and Patricia Denney substituted for Dave Hill.

13/19 MINUTES OF PREVIOUS MEETING: 7 MARCH 2019 [Item 2]

The minutes were agreed as an accurate record of the meeting.

14/19 DECLARATIONS OF INTEREST [Item 3]

There were none.

15/19 QUESTIONS AND PETITIONS [Item 4]

a MEMBERS' QUESTIONS [Item 4a]

None received.

b PUBLIC QUESTIONS [Item 4b]

None received.

c PETITIONS [Item 4c]

None received.

16/19 DRAFT JOINT HEALTH AND WELLBEING STRATEGY [Item 5]

Witnesses:

Justin Newman, Director of Devolution – Surrey Heartlands

Key points raised during the discussion:

1. The Director of Devolution introduced the feedback from the draft Strategy to the Board and spoke about the engagement period that had taken place, telling Members that approximately 160 online responses and 12 letters had been received. He reminded the Board that work had been done with stakeholders and experts, as well as through the use of the Joint Strategic Needs Assessment (JSNA), previous surveys and workshops.
2. The Board agreed Recommendation 1 as set out in the proposed changes to the draft Health and Wellbeing Strategy, namely: "The Health and Wellbeing Board are asked to note the response to the priorities, population groups and level of ambition included within the draft Health and Wellbeing Strategy."
3. A discussion was had about Recommendation 2, which was concerned with changes to the wording and layout of the Strategy. The Chairman expressed his opinion that the Strategy needed to be as easy to understand as possible, with normal, plain English being used throughout.
4. Referring to recommended changes to the section on population groups, the Police and Crime Commissioner questioned whether the Surrey Minority Ethnic Forum had contacted officers about the Strategy and was informed that they had. He also spoke about how pleased he was that illegal drug taking and the associated health impacts had been given attention in the Strategy.
5. The Chief Executive of Healthwatch Surrey expressed her satisfaction with the draft Strategy and how clearly its aims had been expressed. She then went on to discuss the further engagement needed to ensure that as wide a range of residents as possible were consulted. This would ensure that the Strategy's priorities and measurements resonated with both the wider public and those who have had direct experience with the Surrey health system. The Director of Devolution agreed and told the Board that the Strategy would continue to develop during the next phase of its implementation.
6. Recommendation 2 was agreed by the Board.

7. The Board moved on to discuss Recommendation 3, which was concerned with further work that needed to be undertaken on measuring outcomes for the Strategy. The Director of Devolution explained that the Executive Director of Public Health and Wider Determinants of Health would lead this work through the Surrey Office of Data Analytics, and the Chairman spoke about the need to clearly demonstrate that outcomes were improving year on year. In response to a point made by the Leader of Mole Valley District Council about the importance of involving district and borough councils, the Chairman went on to say that it would only be possible to successfully deliver the Strategy's aims if constant collaboration was undertaken with key partners throughout the implementation process.
8. Recommendation 3 was agreed by the Board.
9. The Director of Devolution spoke about Recommendation 4, which was concerned with the implementation phase of the Strategy. The Board agreed to note the feedback outlined in the report and ensure it was shared with priority leads to help inform the Strategy's implementation.
10. Discussion then turned to Recommendation 5, namely: "The Health and Wellbeing Board are asked to note the above feedback and ask officers to share with the appropriate organisations to enable its use in informing future service improvements." The Director of Devolution explained that a number of pieces of feedback did not sit within the scope of the Strategy but were captured for future reference. The recommendation was then agreed by the Board.
11. Moving on to Recommendation 6, the Director of Devolution spoke about the feedback that was received but did not result in any changes to the Strategy being proposed. As an example, he talked about the suggestion to split targeted population groups and the belief that it was better to keep those together for the purposes of the Strategy.
12. Recommendation 6 was agreed by the Board.
13. The Chairman stated that the feedback was a key framework for moving the Strategy forward. He then then turned to the item's three main recommendations, with the first two ("Consider the feedback received during the formal engagement period on the draft Health and Wellbeing Strategy" and "Agree any proposed changes to the draft Health and Wellbeing Strategy") were agreed by the Board.
14. A discussion was had about Recommendation 3, which was concerned with officers being given permission to finalise and publish the Strategy before the end of April 2019. The Chief Executive of Healthwatch Surrey expressed her concern at the metrics not being finalised and asked what Board Members were agreeing to sign off if there was to be another phase of engagement that would inform those metrics. In response, the Director of Devolution confirmed that in six months' time the Board would be able to view a refreshed set of metrics, with the feedback gained during the formal public engagement period influencing these.
15. Recommendation 3 was then agreed by the Board.

Actions/further information to be provided:

None.

Resolved:

3

The Board:

1. Considered the feedback received during the formal engagement period on the draft Health and Wellbeing Strategy.
2. Agreed proposed changes to the draft Health and Wellbeing Strategy.
3. Agreed for officers to finalise and publish the Strategy before the end of April 2019.

17/19 DATE OF THE NEXT MEETING [Item 6]

The next public meeting of the Health and Wellbeing Board will be held on 6 June 2019.

Meeting ended at: 1:40 pm

Chairman

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

1. Reference Information

Paper tracking information	
Title:	Improving Healthcare Together 2020 - 2030
Related Health and Wellbeing Priority:	'Your Health'
Author (Name, post title and telephone number):	Andrew Demetriades, Programme Director Improving Healthcare Together Programme 2020 - 2030
Sponsor:	Dr Russell Hills
Paper date:	22 May 2019
Version:	Version 1
Related papers	N/A

2. Executive summary

The Improving Healthcare Together (IHT) 2020-2030 programme is led by experienced GPs from NHS Surrey Downs, Sutton and Merton Clinical Commissioning Groups (CCGs).

We are working with Epsom and St Helier University Hospitals NHS Trust (ESTH) to address a series of long-standing challenges and improve healthcare for local people in the future.

This reports outlines the progress to date with the programme of work and the next steps prior to any potential public consultation.

3. Recommendations

The Health and Wellbeing Board is asked to;

a) Note the update on progress with the Improving Healthcare Together programme
b) Consider any further information or updates the Board would like to receive in due course

4. Reason for Recommendations

The CCGs are proposing changes to NHS services in the local area, which have the potential for positive improvements in services but will have different impacts on local communities that are served by ESTH. Therefore, the Health and Wellbeing Board is invited to engage in the programme and work with the CCGs to ensure that all aspects of the proposals are understood. The south west London and Surrey JHOSC sub-committee is exercising its scrutiny role separately in relation to the IHT programme.

5. Detail

a) Case for Change and the Proposed Clinical Model

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

NHS

NHS Merton, Sutton and Surrey Downs Clinical Commissioning Groups (CCGs) are looking in detail at the challenges faced by the Trust and how we can make sure the hospitals continue to deliver high quality, safe and sustainable services for local people in the future.

We are looking to address the significant challenges at Epsom and St Helier hospitals around clinical standards, finances and estates.

Epsom and St Helier is unable to meet the clinical standards for six major acute services to deliver high quality care 24/7. Based on the agreed standards, there is a shortage of consultants in emergency departments, acute medicine and intensive care. The Trust is not meeting the Royal College of Emergency Medicine guidance for consultant cover, something recently identified by the Care Quality Commission (CQC). Additionally, there is also a shortage of middle grade doctors and nursing staff.

Many of the Trust's buildings were built before the NHS was founded and are rapidly aging. They are not designed for modern healthcare, an issue repeatedly highlighted by the CQC. The Trust has a very significant and critical backlog of maintenance and the deterioration of the estate is affecting the day-to-day running of clinical services and patients' experience.

Finally, the Trust has an underlying financial deficit which is getting worse each year and will continue to do so unless changes are made. This growing deficit is driven by unavoidable increases in costs for clinical workforce including temporary staff, increasing costs for estates maintenance and less opportunities for changing the way we work.

The CCGs want to improve patient care by making sure local people have the best quality health services in the future, in modern, safe buildings with the majority of services provided on both hospital sites and in the community, close to people's homes.

There is widespread clinical support for the change and the programme's Clinical Advisory Group has led the process of developing a future model of care to address the challenges that have been identified.

The CCGs are clear that we will continue to need both current hospitals. The majority of hospital services (district services) will remain unchanged and available on both the Epsom and St Helier hospital sites.

These district services do not rely on critical care and are becoming more closely integrated with community and home services through existing CCG plans. They include:

- Urgent treatment centres
- Medically stable inpatients
- Outpatients
- Day case surgery
- Ante/post-natal clinics
- Chemotherapy
- Dialysis
- Endoscopy
- Imaging and diagnostics

The IHT programme of work is looking at solutions to the small number of major acute services that need to change; accident and emergency care (adults and children), acute medicine, critical care, emergency surgery, inpatient paediatrics and hospital births.

The work to date on the clinical model suggests elements of all six major acute services should be co-located on one site, and there are three potential solutions:

- Locating major acute services at **Epsom Hospital**, and continuing to provide district services at both Epsom and St Helier hospitals.
- Locating major acute services at **St Helier Hospital**, and continuing to provide district hospital services at both Epsom and St Helier hospitals.
- Locating major acute services at **Sutton Hospital**, and continuing to provide district services at both Epsom and St Helier hospitals.

Every solution currently being considered will mean urgent treatment centres are available on all sites. Antenatal and postnatal care, outpatients and diagnostic services would also be retained at both Epsom and St Helier hospitals under all three solutions.

Arranging our district hospital services and major acute services in this way would bring a range of benefits for our patients:

- Better clinical standards for our sickest patients and those most at risk of becoming seriously ill, with consultant cover that meets regional and national safety standards.
- Patients will have access to the right specialist at the right time which means they are more likely to have a better outcome for their health.
- We will be delivering the majority of care close to home and joined up with GPs, social care and community care.
- Better facilities impact on patient care by being more efficient and easier to maintain and clean – this means a reduced risk of hospital-acquired infections and a better environment for healing.
- Centralising major acute services onto one site means we can access the latest technology and equipment for patients so they have the best possible chance of a better outcome when they are seriously ill.

b) Integrated Impact Assessment

The IHT programme has commissioned independent specialists Mott Macdonald to undertake an Integrated Impact Assessment (IIA) to understand the full range of potential impacts that proposals could have on the local population and potential solutions.

The IIA takes place in three phases:

The **Integrated Impact Assessment phase one** is completed and includes:

- An Initial Equalities Analysis
- A Deprivation analysis
- A phase one Travel Time analysis

The **Integrated Impact Assessment phases two and three** - phase two is nearing completion and an interim report will be published in June 2019. The third and final phase is planned to run after a

public consultation and is published prior to making any decision making. The assessment explores health, travel and environmental impacts and will include in-depth engagement with a range of local people from different backgrounds and protected characteristic groups.

The second phase which started in January 2019 aims to:

- Engage with different equality groups to explore the perceived needs and impacts identified in phase 1 of this work and to determine any other potential impacts (if any)

- Comprehensively assess any positive and negative impacts of the options across four areas: equality, health, travel and access, and sustainability

An IIA Steering Group has overseen the delivery of this programme of work. This group has been independently chaired and comprises of representation from across the combined geographies including CCGs, local authorities, public health, Healthwatch and voluntary sector representatives, as well as representation from the travel and access working group.

c) NHS Provider Impact Assessment

The IHT Programme is continuing to work with local NHS hospital and ambulance providers to understand the potential impact of each option.

The potentially affected providers are: Epsom and St Helier, Kingston, Croydon, St George's, Ashford St Peter's, Royal Surrey and Surrey and Sussex and the London Ambulance Service and South East Coast Ambulance Service.

Providers are now completing detailed impact assessment for each of their Trusts in four areas, capacity, estates and capital, income and expenditure and workforce. This work will be completed by early June and this will then be considered further by the CCGs to understand the relative impacts, as a key strand of additional evidence that will need consideration prior to any pre-consultation decision making process.

d) Regulator Assurance

In December 2018 we submitted our draft Pre-Consultation Business Case (PCBC) for assurance to NHS England and NHS Improvement. Our plans are undergoing an assessment by NHS regulators to make sure they are robust and can deliver the very best future care to local people.
Our plans have also been reviewed by a joint independent Clinical Senate from London and the South East, to make sure our options are the best clinical model for local people. We will consider their recommendations and publish the report later in June 2019.

e) Finance, Activity and Estates

The IHT Programme is continuing to develop our financial analysis and this will be informed by feedback received as part of the assurance process.

The programme is developing a proposition for how the capital needed will likely be sourced, for example how much money from central government will likely be needed. The programme will need

to determine the most appropriate financing route as well as secure support in principle for the capital investment needed prior to launching any formal public consultation.

6. Challenges

We will not proceed to public consultation until we have secured support in principal for capital funding from NHS England and NHS Improvement to make the necessary investment required. This will only be secured once our plans have been assessed by regulators - both regionally and nationally in line with normal NHS planning requirements.

We are continuing to explore future potential funding options which could be available and are working closely with regulators, to test and refine these.

The timing of any consultation will be considered in the light of national advice and guidance from NHS regulators on the readiness to proceed.

7. Timescale and delivery plan

We have published an indicative timeline for the programme which is subject to change and is kept under review by the IHT programme board with the support of NHS Regulators.

Appendix 1 includes an outline of the IHT programme timeline.

8. How is this being communicated?

The Improving Healthcare Together 2020-2030 programme launched its communications strategy in June 2018 with a public engagement plan introducing an Issues Paper. We have followed NHS England guidance for public engagement and are being assured independently by The Consultation Institute (tCI). We have and are continuing to engage a wide variety of people through different activities including:

- 12 public discussion events
- 6 high street and mobile engagement events
- 6 focus groups with people who use the following services: maternity, paediatrics and A&E
- 15 independently facilitated workshops and focus groups with protected characteristic, seldom heard and deprived communities
- Community outreach with 18 equalities groups flagged by the initial equalities analysis
- Emails, letters, telephone calls and via our website, Twitter and Facebook

The programme continues to work with its Stakeholder Reference Group as part of its core governance arrangements. This group scrutinises our plans and ideas and makes recommendations to enhance the proposals.

We have already heard from more than 1,000 people and organisations. The feedback is helping to shape our proposals providing us with challenge as well as ideas. All information gathered from the engagement activities has been collated and analysed independently by The Campaign Company and published on our website here. We have also published several reports on the work we have done to engage protected characteristic groups under the Equalities Act 2010.

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

As well as the early engagement work, in November 2018 we ran three further independently facilitated workshops with members of the public, NHS professionals and other experts to consider the work to date around developing potential solutions. These workshops were part of our options consideration process which is still ongoing.

We have also undertaken a further period of public engagement as part of the second phase of the Integrated Impact Assessment (IIA) which has included a wide range of focus group discussions with people from protected characteristics groups in the three CCG areas and people living in deprived communities.

9. Next steps

The three CCGs will consider feedback from the assurance process, the Integrated Impact Assessment, the provider impact assessment, and any further evidence before deciding if they wish to proceed to public consultation on any proposals.

We will continue to work with local people, community groups, councils and NHS regulators to test all our options as well as all of the work we have done to date.

We will make a decision about whether to proceed to public consultation on any of the options after we have been through the assurance process with NHS England and NHS Improvement, and after we have agreement in principle to the capital funding.

Appendix 1: Outline IHT Programme Timeline

Improving Healthcare Together 2020-2030
NHS Surrey Downs, Sutton and Merton CCGs

	Phase	Outputs	Governance route	Decision point
1	Pre-consultation engagement	• Early engagement on *Issues Paper*, including case for change, emerging clinical model and provisional solutions development framework • Phase 1 Integrated Impact Assessment (IIA) scoping: initial equality analysis and baseline travel analysis	June 2018 **Committees in Common in public**	**Decision to engage on *Issues Paper***
2	Initial option consideration	• Public and stakeholder feedback on engagement activities • Co-production of non-financial criteria, weighting and scoring of options	June – November 2018	
3	Regulatory assurance	• Draft Pre-Consultation Business Case submitted to NHS regulators • Provider impact analysis and Phase 2 IIA development • Regulator review of PCBC and Clinical Senate review of clinical model • Development of consultation plan in conjunction with JHOSC and SRG	December 2018 – June 2019	**WE ARE HERE**
4	Review of assurance and consultation planning	• Further consideration of evidence by Governing bodies • Public engagement on further evidence • Feedback from NHS regulators • Approvals from National oversight (OGSCR) and Investment Committee	June – August 2019	
5	Decision to proceed to consultation	• Final PCBC approval with preferred option(s) identified for consultation • Approval of consultation plan • Governing bodies decision to proceed to consultation	September 2019 **Committees in Common in public**	**Decision to proceed to consultation**
6	Consultation	• Consultation	September 2019 – January 2020	
7	Consideration of consultation outputs & decision making	• Independent review of consultation responses • Consideration of full post-consultation IIA (Phase 3) • Decision on agreed option • Development of decision-making business case for approval by regulators	Spring 2020 **Committees in Common in public**	**Decision to proceed with agreed option**

ALL TIMINGS ARE SUBJECT TO CHANGE AND COMMITTEES IN COMMON APPROVAL

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Health and Wellbeing Board

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Strategy Implementation: End of Life Care Partnership Project
Related Health and Wellbeing Priority:	Those people living with illness and/or disability, including long term conditions, multi-morbidities, people who require support to live independently, and people who require support to die well.
Author (Name, post title and telephone number):	Christopher Tune Policy and Programme Manager (Health and Social Care Integration), Surrey County Council 07790836779
Sponsor:	TBC
Paper date:	6 June 2019
Version:	1.1
Related papers	N/A

2. Executive summary

2.1 The Health and Wellbeing Strategy identified 'helping people in Surrey to lead healthy lives' as one of three interconnected priorities for partners to work together to improve outcomes across the county. An agreed key focus area within this was to help people to live independently for as long as possible and to die well. The Health and Wellbeing Board has asked officers to scope out partnership opportunities to support work around End of Life Care. This paper sets out the current picture of End of Life Care commissioning priorities in Surrey, to enable the Board to scope a partnership project aimed at delivering an equitable, high quality End of Life Care service - to ensure Surrey residents and their families are able to access the care they need, as well as die with dignity in their preferred setting.

3. Recommendations

3.1 The Board is asked to:

3.2 Note the initial scoping work that has taken place to map the End of Life commissioning priorities across Surrey.

3.3 Agree to take forward an End of Life Care partnership project and support the next steps listed in the report.

3.4 Work with its Metrics Team to develop improved measures for End of Life Care

4. Reason for Recommendations

4.1 There are a range of End of Life Care commissioning priorities across Surrey, varying by geography. During Health and Wellbeing Board business meetings discussions, opportunities for the Health and Wellbeing Board to take a countywide approach to develop consistency of communications and develop a cross-organisational commissioning approach to look at the best use of collective public funds were identified. This approach will have a direct impact on the priorities identified in the new Surrey

Health and Wellbeing Strategy, specifically around helping people who require support to die well.

5. Detail

5.1 Death is an inevitable part of life. We will all die and almost all of us will experience the death of someone close to us. Dying well is as important as living well. The care a person receives at the end of their life, and where they receive it, can not only make it easier for them but can have profound impact on their family, friends, loved ones, and the people that deliver the care. It can also leave a lasting impression of the health and care system on all those involved. It is vital that every person who is dying is to be seen as an individual with life yet to live.

5.2 Around half a million people die in England each year. For three-quarters of these people, death does not come suddenly. Instead, it is a process that may take days, weeks or even years, involving a progressive decline in functioning and frequent interactions with health professionals. During this time, many receive some form of end of life care, designed to ease any pain or distress caused by their symptoms, and to maximise their quality of life until the moment of their death. In Surrey, there are approximately 10,000 deaths each year. People nearing the end of their lives often have complex needs, which are predicted to increase as the population is growing and getting older. While improved longevity may be seen as a positive sign, it also means that some people will be living longer but not necessarily healthier. Therefore, the variety of needs to be met will be a serious challenge to health care partners. Cancers, circulatory diseases, respiratory diseases and mental and behavioural disorders are directly responsible for nearly 85% of deaths which are not sudden[1].

5.3 Place of death is an important element to end of life care services. In Surrey, 41% of deaths occur in hospital, followed by 27% in care homes, 20% at home, and 10% in a hospice[2]. The current trend is that the percentage of deaths in hospital and in a hospice is decreasing while the percentage of deaths in care homes and at home are increasing, partly due to a drive to reduce deaths in hospitals. While many would prefer to die at home, it is the quality of care someone receives towards the end of their lives which is essential. It is therefore a priority that commissioners can provide the right care for the individual. This means the right input, from the right people, at the right time, in the right place.

5.4 End of Life Care comes in a variety of different forms, often with health and care organisations working in partnership. Wider partners in Surrey's health and care system, including hospices, play a vital role in delivering these End of Life Care services across Surrey. Hospice care receives around a third of its income through government funding, and the rest from the public through charities, donation, and fundraising[3]. There are opportunities for Surrey Health and Wellbeing Board to support and maximise the benefits of collaborative working in Surrey, and also to work in partnership around the commissioned End of Life services to achieve more for service users to prevent an overreliance on the work being done by hospices.

End of Life Care commissioning by area

[1] https://www.surreyi.gov.uk/jsna/end-of-life/
[2] https://www.surreyi.gov.uk/jsna/end-of-life/
[3] http://www.hospiceinfo.org/uk-hospice-facts-and-figures/

5.5 There are a range of health and care commissioning priorities and services in different areas in Surrey. In places, these are starting to become more coordinated around ICS/STP footprints to achieve greater consistency of approach. Further detailed scoping work will be carried out in the next stages section listed at the end of the paper.

East Surrey

5.6 Areas of focus include:

- Better identification of people who may be in their last year of life, and implementation of End of Life Care registers
- Patients known to the community as reaching the end of their life being able to die in their chosen setting by developing End of Life Care Plans and the development of an End of Life Care Team
- A helpline for people and carers to get advice and support
- Tackling the stigma of talking about death, so people can have open, positive conversations about their wishes
- Expanding the teams that care for people in their homes, so they can avoid being taken to hospital in their final days
- Improved care for patients in care homes by commissioning GPs to offer targeted support to community care homes focusing on medications reviews, end of life care planning and treating patients outside of acute care settings
- Health Hubs to assist local nursing and care homes in supporting End of Life Care to improve patient experience as well as reduce unnecessary transports to hospital and resultant admissions

Surrey Heath + North East Hampshire and Farnham

5.7 Surrey Heath and North East Hampshire and Farnham CCGs are now working jointly across the Frimley ICS footprint, with Phyllis Tuckwell Hospice Care and Frimley Park Hospital, and have set up an ICS End of Life Steering Group to address the variation in services around the Frimley system – launched on 28 March 2019. Initial workshops have identified the following potential priorities for work:

- The standardisation of a Frimley directory of services
- The rollout of a 'Patient Passport'
- A development of an End of Life Care training and education strategy
- The offer of 24/7 access to specialist symptom control and advice for patients/carers in Frimley South
- Development of a single, electronic Advance Care Plan

5.8 In addition, the following work is progressing in Surrey Heath[4]:

- Funding is being sought in Surrey Heath for Death Café pilots, to provide guided conversations on End of Life for younger people to think about what they want and to inform the conversations they have with older family members
- Working across the ICS on the implementation of ReSPECT (new extended version of DNACPR forms) and the Future Planning Template (when Summary Care Records are in place)
- Continued encouragement of practices to utilise IBIS notes for improved end of life care

[4] Surrey Heath CCG Cancer and End of Life 2019/20 Plan

- Continuation of the Psychological Debriefing support for community nursing team, which has seen reductions in staff sick leave since implementation
- DNACPR training programme implementation across the Integrated Care Team
- End of Life Care pathway updates and broader circulation with health and social care partners including Continuing Healthcare
- Integration with Frailty Project
- Improving the quality of general practice initial assessments and documentation for patients on admission to nursing homes

Surrey Heartlands

5.9 Consideration is being given to bring together End of Life Care work on a Surrey Heartlands footprint through the creation of a Strategic End of Life group, and linking in with the Surrey Heartlands Academy as a part of the quality improvement redesign work taking place.

5.10 Surrey Heartlands has introduced the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), which is in the early stages of roll-out. Documentation was launched in April 2019 and further development is planned in order to create a platform for an electronic version of the ReSPECT document to enable live, electronic sharing across all providers. This process has been managed through the ReSPECT Steering Group.

5.11 Challenges remain with Acute Providers, most notably Kingston Hospital and Epsom and St Helier Hospital owing to their geography within the South West London Health and Care System which is currently supported by Co-ordinate my Care. Guildford & Waverley CCG has set out key objectives for palliative and end of life care, which it is working to achieve with its partners:

- Identification – Timely identification of people who have palliative or end of life care needs, regardless of diagnosis
- Assessment – All palliative and end of life care needs and preferences are discussed, assessed and recorded for both patients and their carers
- Care Planning – Patients and carers are provided with security and support by effective care planning
- Co-ordination of care – Care is well co-ordinated and there is good communication between all providers of care
- Choice – Patients live and die well in their preferred place of care
- Care delivery – Patients have access to, and receive, responsive high quality palliative and end of life care 24/7, according to need

5.12 Progress has included the introduction of Proactive Anticipatory Care, a comprehensive patient-centred care planning document. PACe is only in place in Guildford & Waverley. In North West Surrey, Locality Hubs have been established in Woking, Ashford, and Walton with a remit to improve care around dementia and End of Life Care. Success has also been had in the past through Coordinated End of Life Service (CoSI) – a community-based end-of-life care service aimed at improving the patient's experience of receiving care at home in the last six to eight weeks of life.

5.13 In Surrey Downs, a 2016 review indicated a low number of palliative care patients were 'dying in their preferred place of death' and were experiencing, on average, three unscheduled hospital admissions during their last year of life. Many of these admissions were deemed unnecessary and caused significant impact to the 'dying' patient, their

families and their carers. In response, Surrey Downs developed an End of Life Care strategy with the following workstreams:

- End of Life Care Collaborative
- Equality and experience
- Volunteer action
- Medicines Management
- Train & Education
- Fast-track & Personal Health Budgets

5.14 Project progress has stalled, although there has been the agreed recruitment of four Community Matrons to the Quality Care Home Team to provide reactive care, support and provide education to Care Homes for patients nearing their end of their lives, assist in the implementation and completion of the ReSPECT documentation, reduce the number of unscheduled admissions in the last year of life, and support the individual's preferred place of death.

Role of the Health and Wellbeing Board

5.15 The Health and Wellbeing discussed the current provision of commissioned services at a business meeting on 09 May 2019. The prevailing opinion was that operational programmes, such as delivering consistency of Proactive Anticipatory Care plans, and the rollout of ReSPECT should rest locally with commissioning organisations – but that the Health and Wellbeing Board should facilitate system-wide discussions to support these as required. The Board outlined that there were two main opportunities for intervention:

- Undertake an effort to raise the profile of End of Life Care and support a collective engagement campaign to initiate a public debate on dying well. The exact scope is yet to be defined, but could include aligning End of Life Care information and training to existing workforce training programmes within Surrey's health and care system, as well as a communications campaign including the wider public.
- Support and facilitate member organisations to undertake a system-wide financial evaluation of End of Life commissioning to look at delivering best value for public money and identify opportunities to join up.

6. Challenges

6.1 The variety and complexity of service delivery across the geography of Surrey presents challenges in terms of delivering a consistent approach. However, the membership and remit of the Board allows the opportunity for a county-wide, system-wide approach. There will be interdependencies with the local End of Life care work that is being carried out at a local CCG level, as well as at a wider STP/ICS footprint.

7. Timescale and delivery plan

7.1 The timescales are set out in Section 9. The exact content of the work is to be scoped by the Board, in partnership with wider stakeholders. It is recommended that the Health and Wellbeing Board Metrics team continue to work to develop improved End of Life Care metrics, and continue to bring in learning of effective measures being taken across the country. These metrics should reflect that the effective management of an individual's

symptoms is the focus of work, and that preferred place of death be used a proxy measure, rather than targeting a specific setting.

8. How is this being communicated?

8.1 Initial conversations have taken place with CCG representatives to understand current areas of work. Further engagement will be required to shape the content of the Health and Wellbeing Board's work. Wider communications will be needed with a range of health and care organisations, voluntary sector organisations, care providers, service users, and families. There may be a role for the Board in a wider communications campaign regarding End of Life Care to increase public awareness. This will be developed in consultation with the Health and Wellbeing Board Communication Group.

9. Next steps

Stage one: Develop the End of Life Care partnership project proposal (June-July)

- We will use the self-assessments carried out by areas in Surrey as a part of the Ambitions for Palliative and End of Life Care National Framework to identify opportunities for system improvement
- We will engage with key stakeholders to develop a consistent End of Life communications approach, working with the Health and Wellbeing Board Communication Group
- We will work as a system, with commissioning organisations and wider stakeholders, to identify opportunities for joined-up commissioning using shared resources where possible
- The Health and Wellbeing Board Metrics Team will work to develop, benchmark, and monitor robust End of Life Care metrics

Stage two: Test with stakeholders (August)

- We will test our proposals with partner organisations, providers, Surrey residents and our workforce to develop the proposal further and test out the different levels of engagement.

Stage three: End of Life Care partnership project implementation (TBC)

- We will implement the final proposals, as developed and tested with partners
- We will monitor the progress of the established End of Life Care metrics to measure improvement

Health and Wellbeing Board

1. Reference Information

Paper tracking information	
Title:	Draft Implementation Plan
Related Health and Wellbeing Priority:	Priority 1: Helping people live healthy lives
Author (Name, post title and telephone number):	Ruth Davison, Deputy Director of Public Health, Surrey County Council, 0208 541 7801
Sponsor:	We do not yet have a confirmed Priority One sponsor
Paper date:	6 June 2019
Related papers	Annex 1 – Draft Implementation Plan

2. Executive summary

2.1 This paper introduces the draft implementation plan for Priority One: 'Helping people to live healthy lives.' Following approval, we will begin engagement on the draft implementation plan with key stakeholders and partnerships. The Surrey Prevention and Wider Determinants of Health Board will sign off the final implementation plan in the autumn before it is brought to the Health and Wellbeing Board for approval in December.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to:

a) Approve the draft implementation plan subject to any suggested changes
b) Agree to work in partnership to develop the final detailed implementation plan

4. Reason for Recommendations

4.1 Following initial engagement with work leads across the seven areas of focus in Priority One, the draft implementation plan one sets out the activity required to improve the outcomes set out in the Health and Wellbeing Strategy.

4.2 By approving the draft plan, the Health and Wellbeing Board are agreeing to work in partnership to identify work leads and shared resource, developing a detailed final plan to bring back to the board in December.

5. Detail

5.1 At the Health and Wellbeing Board business meeting on 9 May 2019, board members discussed the seven areas of focus for Priority One. Since then, officers have engaged with stakeholders to put together a draft implementation plan. The draft plan sets out the key outcomes and activity required to improve health outcomes in Priority One of the strategy.

5.2 Key work leads across health, districts and boroughs, police and social care have been involved in identifying gaps in provision. We are also engaging with representatives for each of the target groups in the strategy on the implementation plans. The draft plan will also be taken to the Surrey Prevention and Wider Determinants of Health Board (the delivery board for priority one) on 5 June 2019 for their approval of the draft and establishing mechanism for further engagement and programme management.

5.3 Following agreement from the Health and Wellbeing Board, we will engage with key stakeholders and partnerships to shape the plans over the next six months across the whole of Surrey, including representatives from Surrey Heath, Farnham and East Surrey. We will work closely with the Surrey Prevention and Wider Determinants of Health Board to complete a detailed final plan to bring back to the Board in December.

5.4 The Surrey Prevention and Wider Determinants of Health Board is currently reviewing its terms of reference to become the Surrey-wide delivery board for Priority One. The final plan, which will map delivery milestones and KPIs, will be monitored by the Surrey Prevention and Wider Determinants of Health Board. Each milestone will have a named owner and timescale for delivery. Key issues, risks and highlight reports will be brought to the Health and Wellbeing Board where appropriate.

5.5 Links to each capability have been mapped out in the draft implementation plan. We are currently developing plans for each capability and will update the board in due course. These plans will also be working documents, reviewed annually to agree activity.

6. Challenges and dependencies

6.1 There are a number of dependencies to note in the draft implementation plan. Many of the areas of focus such as ‘Supporting prevention and treatment of substance misuse, including alcohol’ are linked to other priority areas such as mental health and emotional wellbeing.

6.2 There are also programmes, such as Making Every Adult Matter, that link to and are dependent on other priorities, as well as the system capabilities. The final plans will make these links explicit through agreed activity, an identified lead and actions.

6.3 A key challenge will be to ensure the implementation plan is owned across the health and wellbeing partnership to ensure more joined up delivery and wider system change.

7. Timescale and delivery plan

7.1 The Health and Wellbeing Strategy is a 10-year strategic plan. However, the detailed implementation plans will be reviewed annually. The KPIs are currently under development by SODA (Surrey Office of Data Analytics) for the Health and Wellbeing Board and will be finalised alongside the final plan for the Board meeting in December.

8. How is this being communicated?

8.1 A meeting has been arranged with members of the Health and Wellbeing Communications Group to discuss communications campaigns and stakeholder engagement.

8.2 The draft implementation plan also includes suggested activity on communications campaigns and stakeholder engagement, all dependent on available resource.

9. Next steps

- 5 June – Formally agree the new terms of reference for the Surrey Prevention and Wider Determinants of Health Board to become the delivery board for Priority One
- 10 June – Begin engagement on the draft implementation plan with key stakeholders and partnerships
- The Surrey Prevention and Wider Determinants of Health Board sign off the final implementation plan in the autumn
- 5 December – The final implementation plan is brought to the Health and Wellbeing Board for approval
- Annex One is the full draft implementation plan, which includes a matrix on the developing metrics

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Focus area
What we are trying to achieve

Activity
What we will do

Outcomes
What we need to achieve

KPIs 19/20
We will know that we are on track when…

Ensuring that everyone lives in good and appropriate housing

- Map of existing homeless initiatives, housing data and gaps (Ooinika Efobi, Health and Social Care Integration, SCC)
- Develop a jointly commissioned pathway for single, homeless people with complex needs (Making Every Adult Matter) (Amy Morgan/Phill Austen-Reed, Public Health, SCC)
- Development of a South East regional offer to enable Surrey to deliver on its duty to provide secure accommodation and support to victims of domestic abuse (tbc)
- Put in place support for people living in overcrowded environments, as well as those under-occupying and empty homes (tbc)
- Develop a fuel poverty offer for those living in crisis (tbc)
- Fully implement the Surrey aids and adaptations review to ensure there is a consistent adaptations service available across Surrey (Tony draper, Senior Commissioning Manager, SCC)
- Develop specialist housing, integrated into care pathways and aligned to the reablement programme (Mike Boyle, Head of Commissioning, SCC)

People who require support live in appropriate housing with easy access to the services they need

People live in adequate housing with access to services

People with a learning disability and/or autism live in adequate housing with adequate support

People live independently at home for as long as possible

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact
We will know we have achieved this when…

- Increased number of older people at home 91 days after discharge
- Reduced emergency admissions rates of those with dementia
- Reduced excess winter deaths
- Number of supported adults whose accommodation status is severely unsatisfactory is reduced
- Increased number of people with a learning disability living in settled accommodation)
- Reduced overcrowding
- Reduced homelessness rates and number of people experiencing severe and multiple disadvantage

Strategy Lead	Siobhan Kennedy/Rod Brown	**Support**	Amy Morgan
Related priorities	Priority 2 (emotional wellbeing and mental health)		
Related workstreams	Link to healthy environments; domestic violence; substance misuse and programme to address access to substance misuse and mental health services for those with severe and multiple disadvantage		

System Capabilities:

Clear Governance
- Develop a formal Surrey housing and health partnership to strengthen joint working (Lead – Rod Brown and Amy Morgan)

Community development:
- Communications campaign on fuel poverty (tbc not 19/20) (Lead – tbc))
- Joint communications strategy for Making Every Adult Matter (MEAM) (Lead – Amy Morgan, Health and Social Care Integration, SCC)
- Incorporation of MECC approach into housing sector and establish housing staff trained in the approach (Joint Lead – Jenn Smith, SCC and Amy Morgan, SCC)
- Review of social prescribing initiatives to support outcomes (Lead – Rebecca Brooker, Community Development Lead, SCC)

Estates:
- Support to scope a partnership project on integrated, specialist housing and align with reablement programmes (Joint Lead – Sarah Ford and John Woodruff, SCC)

Workforce and culture:
- Joined up workforce development plan, policies and procedures, and shared principles for Making Every Adult Matter (Amy Morgan, SCC)

Focus area
What we are trying to achieve

Every child and adult experiencing DA to be seen, safe and heard and free from harm of perpetrator behaviour

Activity
What we will do

- Establish a defined pathway for families at risk of DA to focus on Adverse Childhood Experiences within First 1000 days (Lead tbc)
- Review DA support available across partners (Lead - Joanne Parkinson, Strategic Commissioning, SCC)
- Develop an offer to primary care to identify, respond and refer to incidents of domestic abuse at the earliest opportunity (such as IRIS, a GP training support and referral programme) (Lead tbc)
- More A&E Independent Domestic Violence Advocates (IDVA) to do brief interventions for survivors and sometimes perpetrators (building on existing provision in Ashford and St Peters) (Lead tbc)
- Include the ambitions of Making Every Adult Matter (MEAM) as part of the recommissioning process for the domestic abuse service (Lead - Amy Morgan, Health and Social Care Integration, SCC)
- Ensure victims and perpetrators of domestic abuse experiencing multiple and severe disadvantage access the right services at the right time (i.e. refuges that accept victims with substance misuse issues, and perpetrators receiving support to tackle mental health conditions) (Lead – tbc)

Outcomes
What we need to achieve

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

KPIs 19/20
We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact
We will know we have achieved this when…

Under development by SODA
- Increased referrals from primary and acute care to specialist outreach
- Increased number of perpetrators supported to reduce reoffending by addressing substance misuse and mental health
- Increased number of survivors who are self-medicating (drugs/alcohol) accessing the right support as part of integrated support pathway

Strategy lead	Joanne Parkinson	**Support**	Amy Morgan
Related priorities	Priority 2 (emotional wellbeing and mental health)		
Related workstreams	**Substance Misuse, good and appropriate housing**		

System Capabilities

Community Development:
- Joined up working between the HWB comms groups and DA comms group to develop the next DA campaign (Lead – tbc)
- Link the Ask Me advocates with the social prescribers and incorporate into the preventative workforce approach (Lead – Rebecca Brooker, SCC)
- Incorporate MECC approach into domestic abuse agenda, linking to the Ask Me advocacy programme (Jenn Smith, SCC)

Workforce and culture:
- Quality assured joined up workforce development plan, policies and procedures, and shared principles for domestic abuse (Joint Lead – Joanne Parkinson, SCC/tbc)

Healthy Surrey

DELIVERING THE COMMUNITY VISION FOR SURREY

Focus area
What we are trying to achieve

Supporting prevention and treatment of substance misuse, including alcohol

Activity
What we will do

- Refresh the Substance Misuse Strategy with a wider consultation including alcohol partners (Gail Hughes, SCC)
- Develop an Alcohol & Tobacco Alliance to increase focus on alcohol prevention and improve universal approaches to reducing increasing and higher risk drinking (Gail Hughes, SCC)
- Refresh the Substance Misuse Partnership to have a greater focus on alcohol (Martyn Munro, Public Health, SCC)
- Integrate and align Health behavior strategies and services across the Life Course (Jenn Smith, Public Health, Surrey CC)
- Identification and Brief Advice embedded in clinical pathways across primary and secondary care including, e.g. ED, IAPT and Social Prescribing and Alcohol Action Teams in ED's. (Gail Hughes, SCC)
- Health Checks targeted to Carers, those with SMIs and people with Learning Difficulties (Jenn Smith, SCC)
- Develop a programme to address access to substance misuse and mental health services for those with severe and multiple disadvantage (Martyn Munro/ Phillip Austen-Reed, SCC)

Outcomes
What we need to achieve

- A culture of safe and social alcohol use
- A coordinated approach to identification and support for high risk areas and communities
- People are supported to identify and address alcohol risk

KPIs 19/20 – We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact – We will know we have achieved this when…

Under development by SODA:

- Reduced Excessive Alcohol Consumption Rates
- Increased successful alcohol treatment completion rates
- Reduced number of young people (aged 0-17) in specialist substance misuse services

Strategy lead	**Gail Hughes/ Martyn Munro**	**Support**	**Lucy Gate**
Related priorities	**Priority 2 (emotional wellbeing and mental health)**		
Related workstreams	**Substance Misuse Partnership Domestic Abuse Strategy Suicide Strategy**		

System Capabilities:

Clear Governance:
- Work towards alignment of investment across partners (Partnership as identified above)

Workforce and Culture:
- Workforce development to include IBA for Alcohol and MECC embedded in partner pathways and systems (Gail Hughes, SCC)
- Workforce Health Programmes to include support on alcohol and substance misuse (Gail Hughes, SCC/ Lucy Gate SCC)

Intelligence:
- Substance Misuse Partnership to include Data sharing agreements across the system(e.g. primary care, licensing, hospital, police) to enable targeted cross-partner intervention (Tbc)

Community development:
- Engagement with communities, Community development/Healthy Surrey to be at the heart of substance misuse strategy refresh. (Gail Hughes, SCC)
- Develop communications and engagement at a community level to reduce the stigma of presentation (Gail Hughes/Martyn Munro, SCC)

Digital:
- Maximise use of digital interventions to address risky health behaviors (Martyn Munro/ Gail Hughes, SCC)

Healthy Surrey

DELIVERING THE COMMUNITY VISION FOR SURREY

Focus area
What we are trying to achieve

Promoting prevention to decrease incidence of serious conditions and diseases

Activity
What we will do

- Establish Surrey-wide Diabetes testing programme in the workplace (TBC)
- Targeted engagement with key geographies and groups to improve awareness and diagnosis (TBC))
- Promote bowel and cervical cancer screening as a preventative health measure rather than purely for those at risk (Rachel Gill, Public Health, SCC)
- Targeted engagement with key geographies and groups to improve understanding and take-up of childhood immunisations (Rachel Gill, Public Health SCC)

Outcomes
What we need to achieve

- Proactive identification of those who are pre-diabetic and not engaged with GPs
- Primary prevention and self-care
- Bowel cancer screening coverage
- Cervical cancer screening coverage
- Improved childhood immunisations (under 5s) uptake

KPIs 19/20
We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact
We will know we have achieved this when…

- Improved diabetes diagnosis rates
- Improved pre-diabetes rates
- Improved childhood immunisations (under 5s) uptake
- Improved bowel screening rates
- Improved cervical screening rates

Strategy lead	**Rachel Gill**	**Support**	**Lucy Gate**
Related priorities	**Priority 3 (Supporting people in Surrey to fulfil their potential)**		
Related workstreams	**Planned Care**		

System capabilities

Community development:
- Explore requirements for a Surrey-wide communications campaign on childhood immunisations (TBC)

Intelligence:
- Further develop the multi-agency Cancer Screening Forum and working groups to ensure cross organisation data sharing and utilisation of community groups to reach vulnerable and deprived communities who are not known to health services (Rachel Gill, SCC, NHSE)

Workforce:
- Incorporate MECC approach and development opportunities into diabetes pathway (Jenn Smith, SCC)
- Workforce training and awareness raising on diabetes and bowel cancer screening. (TBC)
- Develop reciprocal pathways between screening a preventative health behavior services (i.e. Stop Smoking Service) and embed MECC at key stages in patient pathways (NHSE/Jenn Smith, SCC)

Focus area
What we are trying to achieve

Working to reduce obesity, excess weight rates and physical inactivity

Activity
What we will do

- Develop whole systems approach to physical activity including improving use of green spaces, transport initiatives, and healthy planning (Campbell, Livingstone, Active Surrey/Jenn Smith SCC)
- Integrate and align Health behavior (including sleep) strategies and services across the Life Course (Jenn Smith, Public Health, Surrey CC)
- Implement 'Healthy High Streets' approach with a focus on the most deprived areas and residential care (Jenn Smith, Public Health, Surrey CC)
- Develop a heath behavior offer for deprived and vulnerable groups (including routine and manual workers, pregnant women, carers and those with a learning disability and/or autism) (Jenn Smith, Surrey CC)

Outcomes
What we need to achieve

- An environment and community which enables physical activity and healthy eating across the life course
- Health behaviour offer for vulnerable groups and those with the greatest need
- People with a learning disability and/or autism and vulnerable groups to have access to facilities with healthy eating options

Strategy lead	Jenn Smith	Support	Lucy Gate
Related priorities	Priority 2 (emotional wellbeing and mental health)		
Related workstreams	Active Surrey Healthy Weight Alliance Environment and Green Spaces		

System Capabilities

Estates:
- Review estates and planning to provide an environment supportive of physical activity (TBC, identified though action 1 above)

Community development:
- Launch a hub for health behavior training for care workers and carers and family centres (Jenn Smith, PH, SCC)

Workforce and Culture:
- Develop and roll out a Healthy Workplace Programme to include support for active travel, healthy eating, and physical activity (TBC)

Digital:
- Maximise use of digital interventions to address risky health behaviours (Gail Hughes, Jenn Smith PH SCC)

KPIs 19/20 – We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact – We will know we have achieved this when…

Under development with SODA:
- National Child Weight Management Programme
- Programme reduction in rates of Obesity
- % of physically inactive adults
- % accessing green spaces
- Reduced obesity in adults with Learning Difficulties reported at a health check

Area of focus
What we are trying to achieve

Activity
What we will do

Outcomes
What we need to achieve

Improving environmental factors

- Publish guidance for health and local planning in Surrey (Health Protection Team, Public Health SCC)
- Engage in the Development Consent Order process for airport expansion applications (Spatial Planning, SCC)
- Make rights of way more useful/suited for every day journeys to work and school and encourage contact with the natural environment, through Rights of Way Strategic Plan (Transport Team, SCC)
- Implement the Surrey Transport Plan: Low Emissions Transport Strategy (Transport Team, SCC)
- Establish a Planning and Health Forum to improve collaborative working (Public Health, SCC)
- Deliver Schools Air Quality Programme (runs until July 2019) and Eco Schools (Safer Travel Team, SCC)
- Surrey-wide communications campaigns to raise awareness of the importance of good air quality and environmental sustainability (Health Protection Team, Public Health SCC)
- Implement the Surrey Single Use Plastics Strategy (TBC)
- Support all local NHS organisations to have Sustainable Development Management Plans approved by their board (Health Protection Team, Public Health SCC)

- To promote healthy, inclusive and safe places through planning policies/decisions and transport/highways policy, projects/operations
- Ensure appropriate health infrastructure, by maximising opportunities for health to influence Local Plans and draw on available funds, such as the Community Infrastructure Levy
- People who live and work in Surrey have an increased awareness of the health impact of poor air quality and take action to improve air quality
- People who live and work in Surrey have an increased awareness and take action to support environmental sustainability
- Public sector organisations across Surrey embed environmental sustainability within their organisation

KPIs 19/20 – We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact – We will know we have achieved this when…

Under development by SODA

Strategy lead	**Rachel Gill**	**Support**	**Lucy Gate**
Related priorities	Priority 2 (emotional wellbeing and mental health)		
Related workstreams	Surrey Air Alliance, Surrey Heartlands Sustainability Network, Surrey Planning Officers Association, Surrey Future		

System Capabilities

Governance:
- Explore the use of Health Impact Assessment as a tool to ensure Public Sector organisations develop policies/plans/strategies that support health and wellbeing (TBC)

Workforce Development:
- Implement a workforce health programme to include policies on air quality and sustainability (TBC)

Digital/Community Development:
- Neighbourhood planning and communities to have the Healthy Places toolkit available on Surreyi (TBC)

Healthy Surrey

DELIVERING THE COMMUNITY VISION FOR SURREY

Area of focus
What we are trying to achieve

Helping people to live independently and die well

Activity
What we will do

- Undertake engagement to scope out carers partnership project (Lead – tbc)
- Use the Better Care Fund to engage with wider partners and develop system-wide services (Lead – Chris Tune, Health and Social Care Integration, SCC)
- Develop integrated, countywide response for people living with Dementia (Lead – tbc)
- Support the development of a Technology Enabled Care service (Lead – Tim Cowles, Commissioner, SCC)
- Develop a robust, integrated, preventative Intermediate Care offer (Joint Lead – Amy Howard Operational Lead for Reablement, SCC /tbc)
- Agree a system-wide communication and financial strategy for End of Life Care (Lead – tbc)

Outcome
What we need to achieve

- Individuals that provide unpaid care and support to family and/or friends are supported to enable them to continue their caring role.
- People are supported to manage Long Term Conditions.
- People receive joined-up, person-centered services and only need to tell their story once.
- People are supported to die in a place of their choice.
- People live independently at home for as long as possible.

Strategy lead	**tbc**	**Support**	**Amy Morgan**
Related priorities	Priority 2 (emotional wellbeing and mental health)		
Related workstreams	Dementia Strategy Link to Specialist Housing partnership project		

System Capabilities:

Estates:
- Review and mapping of provision to enable vulnerable groups across Surrey to live independently (Lead - tbc)

Intelligence:
- Integrated health knowledge via IT, ambulance, social care (Julie George, SCC)

Community development:
- Develop Preventative Workforce including Social Prescribing and 'A Million Ways' Programmes to ensure access to information from trusted environments (Lead – Rebecca Brooker, SCC)

Workforce and Culture:
- Implement MECC and the preventative offer across the wider frontline workforce (Lead – Joint Lead – Jenn Smith and Rebecca Brooker, SCC)
- Ensure that staff working with carers are appropriate trained and are "carer aware" (lead – tbc)

KPIs 19/20 – We will know that we are on track when…

- *Under development by SODA (Surrey Office of Data Analytics)*

Impact – We will know we have achieved this when…

Under development by SODA

- Rates of older people still at home 91 days after discharge from hospital
- Emergency admissions rates of those with dementia per 100,000 population
- Rates of deaths in usual place of residence in those aged 65+
- Carer-reported quality of life

Priority 1: Draft Metrics

	General population	Children with special education needs and disabilities (SEND) and adults with learning disabilities and / or autism	Deprived or vulnerable people	People who require support to live with disability and / or illness, live independently, or to die well	Young and adult carers
Helping people to live independently and die well				• Rates of older people still at home 91 days after discharge from hospital • Emergency admissions rates of those with dementia per 100,000 population • Rates of deaths in usual place of residence in those aged 65+	• Carer-reported quality of life (out of 12)
Every child and adult experiencing DA to be seen, safe and heard and free from harm of perpetrator behaviour	• Increased referrals from primary and acute care to specialist outreach • Increased number of perpetrators supported to reduce reoffending by addressing substance misuse and mental health • Increased number of survivors who are self-medicating (drugs/alcohol) accessing the right support as part of integrated support pathway				
Improving environmental factors					
Prevention of disease through vaccination and early diagnosis	• Vaccination rates • Diabetes diagnoses rates • Bowel cancer screening rates • Cervical screening rates				
Ensuring that everyone lives in good and appropriate housing	• Housing affordability ratio • Affordability of home ownership • Housing benefits	• Rates of people with LDs living in settled accommodation	• Reduced overcrowding • Statutory homelessness: rate per 1,000 households • Households in fuel poverty (%) • Excess winter deaths index • Number of people experiencing severe and multiple disadvantage	• Learning disabled people in employment (%) • Rates of supported working age adults whose accommodation status is severely unsatisfactory	
Substance misuse (drugs/alcohol) is low	• Successful completion of alcohol treatment • Number of young people (aged 0-17) in specialist substance misuse services		• Excessive alcohol consumption rates • Smoking rates		
Working to reduce obesity, excess weight rates and physical inactivity	• Obesity admission rate per 100,000 population • Excess weight in adults (%) • National Child Weight Management Programme • % of physically inactive adults • % accessing green spaces	• LD Health Checks	• Obesity rates • Excess weight in adults %		

Health and Wellbeing Board

1. Reference Information

Paper tracking information	
Title:	Developing the Community Development System Capability
Related Health and Wellbeing Priority:	Community Development System Capability
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Sponsor:	Helen Atkinson, Director of Public Health, Surrey County Council Nicola Kilvington, Director of Insight, Analytics and Intelligence
Paper date:	6 June 2019

2. Executive summary

2.1 Community development is identified as a system capability in order to deliver both the Health and Wellbeing Strategy and the 2030 Community Vision for Surrey. The Health and Wellbeing Strategy proposes developing a community development workstream and a community engagement plan.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to:

a) Approve the proposed approach to establish a community development workstream and engagement plan
b) Ensure the activities within the community development and engagement plans are developed in partnership
c) Provide an opportunity at a future board meeting to shape the community development and engagement plans through an in-depth workshop

4. Reason for Recommendations

4.1 During the summer of 2018, residents, communities, voluntary and charitable bodies, faith groups, organisations, public sector bodies, businesses and others from across Surrey worked to set out an ambitious and wide-ranging Community Vision for Surrey in 2030 (the Vision).

4.2 The ambition of the Vision can only be secured through effective partnership working, and to this end the Vision establishes the 'Partnership Commitment', a key theme which is community participation. The Health and Wellbeing Strategy aligns to this by identifying community development as one of the seven system capabilities required to deliver the strategy. There is a breadth of expertise on this across Surrey, but it is currently disconnected and needs to align to the objectives of the Board.

4.3 The recommendations seek to ensure the community development system capability is delivered in a collaborative way for the benefit of residents as well as all partners, to achieve the wider objectives of the Health and Wellbeing Strategy.

5. Detail

5.1 The Health and Wellbeing Strategy identifies community development as one of the seven system capabilities required to deliver the strategy. The critical path to achieve this community development capability was defined in the Strategy as "*creating a new relationship between partners and our population, co-designing and co-producing solutions to our challenges, and improving communication between partners, and with the population*".

5.2 Based on our research, discussions with stakeholders, learning from others and existing work to support this agenda, we propose to take forward work around the following themes in order to deliver on these objectives. These ideas are summarised in Annex 1.

- **Engagement:** Creating a narrative that is clear and straightforward, identifying Surrey's 'natural communities', developing relevant and accessible messaging and engagement at a local level meaningful to the community, building on feedback to create a trusted dialogue
- **Insight:** Talking with residents and partners to agree an understanding of local needs and the things that are important, developing a better understanding of the enablers and barriers to community participation in Surrey, exploring what collaborative opportunities could help make a difference, and seeing if actions are making a difference
- **Asset-based community development:** Enhancing the ability of individuals, families and neighbourhoods to sustain their health and wellbeing by helping them to access and develop local support, utilising local assets to best reach our populations, investing in what is already happening rather than re-inventing the wheel, capturing those in communities who are interested in helping their communities and supporting them to do more
- **Social infrastructure:** The processes and tools that support greater community participation – for example, funding for community projects or digital platforms that provide information and resources
- **Social connections:** Bringing residents together to strengthen relationships within communities and creating new opportunities to build on the community spirit that already exists, making a social movement not just a project
- **Social action:** Working with communities to identify what is important to them and practical solutions to deliver better outcomes, particularly for those that are most vulnerable, identifying actions to meet local needs and 'advertising' them to communities so they can act – resident to resident or with partners and statutory organisations
- **Social innovation:** Taking grass-roots ideas for improving communities and working with partner organisations to help them be nurtured and to flourish. There may also be opportunities to learn lessons or scale up and replicate good practice across Surrey, formalising interest into employability skills especially for those with care and support needs

5.3 The delivery of these themes will be through a range of programmes including:

- **Local Forums:** Local conversations with communities and health and care partners to proactively discuss local needs and collaborative solutions, looking to begin an asset-based approach to commissioning
- **Local Profiles:** A collaboration across community, health and social care to present measures of social wellbeing in an accessible way that could support articulation of local needs, market shaping of the voluntary sector and a common framework for monitoring impact
- **Social Prescribing:** Establishing pathways for residents to make use of community-based support, especially for those accessing primary care for non-medical reasons and for those with avoidable health conditions such as winter wellness
- **Strengths Based Health and Care Practice:** Embedding a strengths based approach within social care and extending this to health partners as appropriate
- **Social Value:** Developing collaboration of communities, statutory partners and Surrey-based businesses to take joint responsibility for the health and wellbeing of Surrey residents
- **A Million Ways**: Digital infrastructure to support resident mobilisation and social action, including resident to resident and resident-organisation
- **Preventative Workforce:** Building community capacity to promote health and wellbeing, by utilising existing points of engagement

5.4 These programmes will be delivered in collaboration with relevant partners, and will be delivered in three phases to allow evolution of the plans as learning develops. The three phases will be:

- **Phase 1 (Scoping and Draft Plans):** Partner and stakeholder co-design and engagement workshops, scoping evaluations, roll out proposals, development of draft community development workstream plan and draft community engagement plan

- **Phase 2 (Prototyping):** Ongoing partner and stakeholder co-design and engagement workshops, development of prototypes, delivery and evaluation of prototype/pilot phases, learning and evolution of community development workstream plan and engagement plan

- **Phase 3 (Delivery at Scale):** Roll out of programmes, evaluation of programmes at scale, review of community development workstream plan and proposals for further activity

5.5 As a result of these activities we expect the following outcomes across Surrey:

- Residents take part in activities that improve their neighbourhood and their health and wellbeing and actively promote health and wellbeing messages
- Residents are more connected with others in their neighbourhood and are working collaboratively together to support their community
- Residents facilitate health and wellbeing initiatives within their communities
- Health and Wellbeing staff across the local system have the a ready network of community representatives to consult and mobilise
- Residents suggest ways health and wellbeing in their neighbourhood could be improved and take part in co-production of local services
- Statutory organisations understand how residents could be involved in co-production or co-delivery of local services
- Employees use more of their employee volunteering allowance to support their workplace or home community

- Residents with care and support needs are contributing to community life
- Residents expressing interest in health and wellbeing are nudged to broaden or deepen their involvement

6. Challenges

6.1 In order to deliver these projects in a timely way and at scale across Surrey, sufficient resources are required. The programmes of work will remain aligned to the ambitions of the Community Vision for Surrey in 2030 and may be subject to change in order to encourage quality partnership working that complements the work of others, and avoids duplication.

7. Timescale and delivery plan

7.1 The programmes will be delivered in stages over the next two years. The delivery plans will be developed in partnership with specific KPIs for each programme.

8. How is this being communicated?

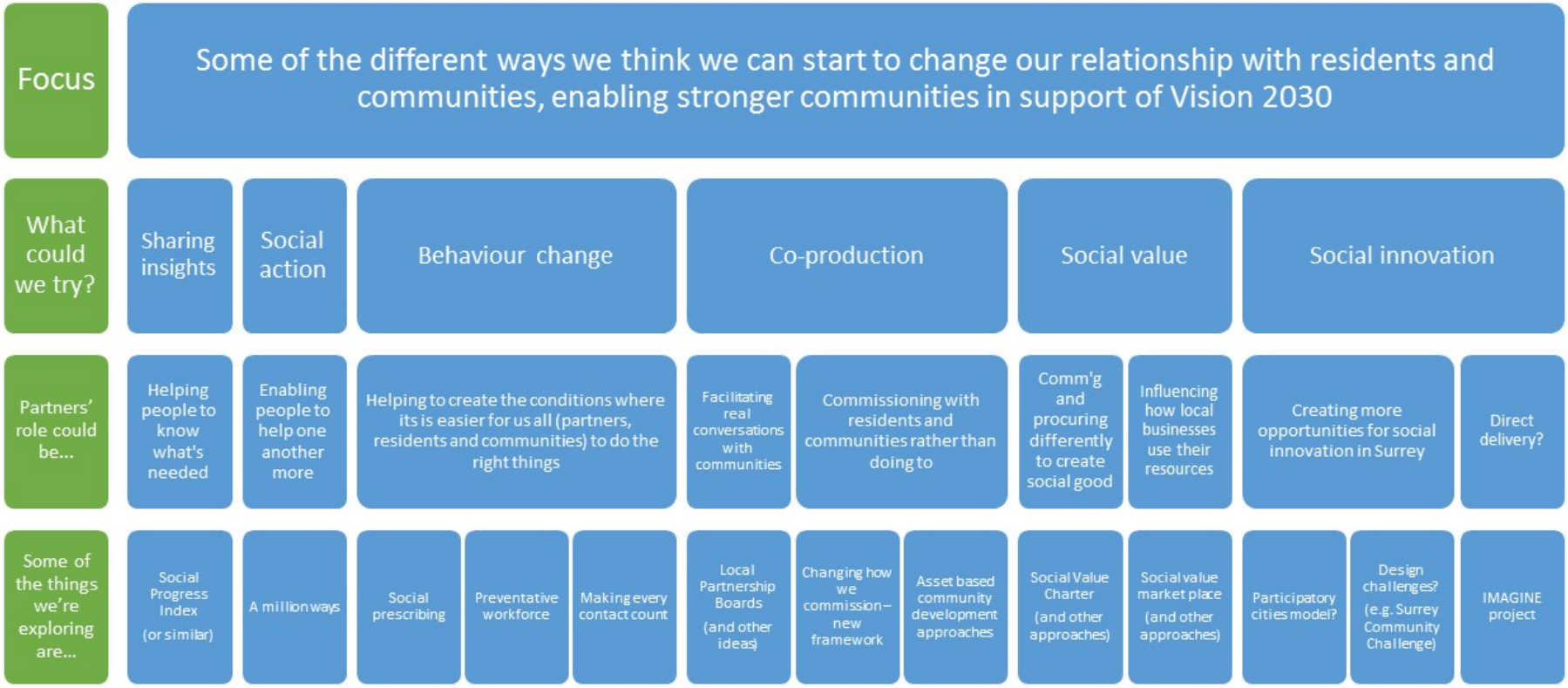
8.1 During the initial scoping phases, wide consultation with stakeholders and partners has begun and will continue. This includes:

- Residents and community representatives
- Voluntary sector organisations and representatives
- Business representatives
- Health and care partners, including primary care, ICPs and Public Health
- Surrey County Council and within district and borough councils

9. Next steps

- Deliver a more in-depth workshop for the Board to shape the proposed approach to developing the community development capability (date to be confirmed)
- Carry out partner and stakeholder workshops to complete scoping of proposed approach and included programmes of work and evaluate feasibility and impact by July 2019
- Develop draft community development workstream plan and draft community engagement plan by August 2019
- Draft proposals and recommendations for the Board on the proposed programmes by September 2019
- Carry out ongoing partner and stakeholder workshops, delivery and evaluation of pilot phases, learning and evolution of community development workstream plan and engagement plan by December 2019
- Begin roll out of programmes and evaluate programmes at scale, reviewing the community development workstream plan and proposals for further activity by July 2020

Annex 1: An outline of community participation models in Surrey



Social Progress Index
- One approach we are exploring to help us measure holistic change over time at a community level and help us focus on the right issues

A million ways
- A small pilot to explore whether an online platform can help to connect residents with needs with to others who want to help local people

Social prescribing
- Work across the Health system to connect patients with non-medical, community based, social interventions in their area

Preventative workforce
- Initial ideas we're exploring about making better use of known networks of staff and residents who want to make a difference in their local areas

Making every contact count
- A well established programme to equip a wide range of professionals and community members to promote public health in their day-to-day work

Local partnership boards
- Planned changes to our current Local and Joint committees (see earlier slides)

Commissioning framework
- Surrey CC developing a new model for its commissioning, focussed on doing with not to, building on the strengths, thinking about systems and enabling shared long-term outcomes

Asset based community development
- Trying out a different approach to working with communities, where we simply support and enable communities to help themselves

Social value charter
- A tool to help us take a consistent and coordinated approach to creating added value for Surrey's communities when SCC spends public money

Social value marketplace
- An online platform to help SCC's providers to identify opportunities where they can give back to local communities

Participatory cities model?
- Work to explore what we can learn from Barking and Dagenham's initiative to support and enable local residents to turn their ideas for change into reality – what would this look like in Surrey?

Design challenges
- Starting to explore whether we can allocate funding to innovative ideas from communities through a more collaborative, value-creating process, rather than classic procurement methods

Imagine project
- A small EU-funded social innovation pilot to co-produce new ways of using public land to create training and employment opportunities for young adults