Notice of Meeting

Health and Wellbeing Board

Date & time
Wednesday,
15 March 2023
at **2.00 pm**

Place
Council Chamber,
Woodhatch Place, 11
Cockshot Hill, Reigate,
Surrey, RH2 8EF

Contact
Amelia Christopher
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If you would like a copy of this agenda or the attached papers in another format, e.g. large print or braille, or another language please either call 07929 725663 or email amelia.christopher@surreycc.gov.uk.

This meeting will be held in public. If you would like to attend, please contact Amelia Christopher.

The live webcast of the meeting can be viewed here: https://www.surreycc.gov.uk/council-and-democracy/councillors-and-committees/webcasts

Board Members

Tim Oliver (Chairman)	Leader of Surrey County Council
Dr Charlotte Canniff (Vice-Chairman)	Joint Chief Medical Officer, Surrey Heartlands Integrated Care System
Karen Brimacombe	Chief Executive, Mole Valley District Council (Surrey Chief Executives' Group) (Priority 1 Sponsor)
Professor Helen Rostill / Kate Barker and Liz Williams	Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS (Priority 2 Co-Sponsor) / Joint Strategic Commissioning Conveners, Surrey County Council and Surrey Heartlands (Priority 2 Co-Sponsors)
Mari Roberts-Wood	Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Fiona Edwards	Chief Executive of the Frimley Integrated Care System
Jason Gaskell / Sue Murphy and Rosemarie Pardington	CEO, Surrey Community Action / Chief Executive Officer, Catalyst / Director of Health, Research & Compliance/Deputy CEO Young Epilepsy (VCSE Alliance Co-Representatives)
Dr Russell Hills	Executive Clinical Director, Surrey Downs Health and Care Partnership
Kate Scribbins	Chief Executive, Healthwatch Surrey
Ruth Hutchinson	Director of Public Health, Surrey County Council
Liz Bruce	Joint Executive Director of Adult Social Care and Integrated Commissioning, Surrey County Council and Surrey Heartlands ICS
Rachael Wardell	Executive Director for Children, Families and Lifelong Learning

Professor Claire Fuller	Chief Executive Officer, Surrey Heartlands Integrated Care System
Graham Wareham	Chief Executive, Surrey and Borders Partnership
Joanna Killian	Chief Executive, Surrey County Council
Mark Nuti	Cabinet Member for Adults and Health, Surrey County Council
Sinead Mooney	Cabinet Member for Children and Families, Surrey County Council
Denise Turner-Stewart	Cabinet Member for Communities and Community Safety, Surrey County Council
Jason Halliwell	Head of Probation Delivery Unit for Surrey at The Probation Service
Carl Hall	Deputy Director of Community Development, Interventions Alliance
Gavin Stephens	Chief Constable of Surrey Police
Borough Councillor Hannah Dalton	Chair of Residents' Association (Majority Group), Epsom and Ewell Borough Council (Surrey Leaders' Group
Steve Flanagan	Representative, North West Surrey Integrated Care Partnership and Community Provider voice
Jo Cogswell	Place Based Leader, Guildford and Waverley Health and Care Alliance
Dr Pramit Patel	Place Based Leader and Primary Care Clinical Leader, East Surrey Place / Surrey Heartlands ICS
Lisa Townsend	Police and Crime Commissioner for Surrey
Deborah Dunn-Walters	Professor of Immunology and leads the Lifelong Health research theme, University of Surrey
Siobhan Kennedy	Homelessness, Advice & Allocations Lead, Guildford Borough Council (Associate Member)

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 MINUTES OF PREVIOUS MEETING: 21 DECEMBER 2022 (Pages 1 - 16)

To agree the minutes of the previous meeting.

3 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.

4 QUESTIONS AND PETITIONS

a Members' Questions

The deadline for Member's questions is 12pm four working days before the meeting *(9 March 2023).*

b Public Questions

The deadline for public questions is seven days before the meeting *(8 March 2023).*

c Petitions

The deadline for petitions was 14 days before the meeting. No petitions have been received.

5 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT (Pages 17 - 82)

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the Health and Wellbeing Strategy (HWB Strategy) in the priority populations as of 21 February 2023. It also has a section on communication activity associated with the HWB Strategy's priority populations and priorities and a section on

the progress of the review of the Joint Strategic Needs Assessment (JSNA) – chapters already published/in development. The draft Frimley Integrated Care Strategy - 'Creating Healthier Communities' is also provided for information.

6 HEALTH AND WELL-BEING STRATEGY INDEX (Pages 83 - 90)

At the September Board we discussed an approach to the development of metrics that would enable an understanding of how effectively we are delivering the Health and Well-Being (HWB) Strategy. In this update, we discuss how we have taken this approach forward and developed a visual means for Board members, partners and Surrey residents to view how the metrics are contributing to the key priorities. The HWB Strategy Index is constructed using a methodology similar to the Surrey Index and will be presented as an interactive dashboard at the March Board meeting. It will then be available publicly via Surrey-i.

7 WIDER DETERMINANTS OF HEALTH: SURREY SKILLS PLAN (Pages 91 - 106)

The Surrey Skills Plan (SSP) was launched in November 2022. The plan forms the strategic basis for delivering skills priorities in Surrey and sets out a collective vision for a dynamic, demand led skills system. The SSP has four strategic objectives, with the second objective 'Supporting People' aligning most closely with Priority 3 of the Health and Wellbeing Strategy. The attached presentation provides an overview of the SSP, an update on the implementation of the Supporting People objective and asks the Board to consider how it can support the delivery of the SSP ambitions going forward.

8 INTEGRATED CARE SYSTEMS (ICS) UPDATE (Pages 107 - 126)

The Board is asked to note the update provided on the recent activity within the Surrey Heartlands and Frimley Integrated Care Systems (ICS) regarding the Integrated Care Partnerships and Integrated Care Boards; including an update on both systems' implementation of the 'Next steps for integrating primary care: Fuller stocktake report'.

9 DATE OF THE NEXT MEETING

The next meeting of the Health and Wellbeing Board will be on 21 June 2023.

Joanna Killian
Chief Executive
Surrey County Council
Published: Tuesday, 7 March 2023

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).
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, Woodhatch Place has wifi available for visitors – please ask at reception for details.

Anyone is permitted to film, record or take photographs at council meetings. Please liaise with the council officer listed in the agenda prior to the start of the meeting so that those attending the meeting can be made aware of any filming taking place.

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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 2.00 pm on 21 December 2022 at Council Chamber, Woodhatch Place, 11 Cockshot Hill, Reigate, Surrey, RH2 8EF.

These minutes are subject to confirmation by the Committee at its meeting on Wednesday, 15 March 2023.

Board Members:
(Present = *)
(Remote Attendance = r)

Fiona Edwards
* Dr Charlotte Canniff (Vice-Chairman)
Jason Gaskell (Co-Representative)
* Rosemarie Pardington (Co-Representative)
* Sue Murphy (Co-Representative)
* Dr Russell Hills
* Tim Oliver (Chairman)
* Kate Scribbins
Liz Bruce
* Ruth Hutchinson
* Professor Claire Fuller
* Graham Wareham
Joanna Killian
Sinead Mooney
* Mark Nuti
* Denise Turner-Stewart
Karen Brimacombe
* Jason Halliwell
* Carl Hall
* Gavin Stephens
* Mari Roberts-Wood
r Steve Flanagan
Jo Cogswell
Professor Helen Rostill (Co-Sponsor)
r Liz Williams (Co-Sponsor)
Kate Barker (Co-Sponsor)
Professor Deborah Dunn-Walters
* Rachael Wardell
Borough Councillor Hannah Dalton
Lisa Townsend
Siobhan Kennedy (Associate Member)

Substitute Members:
* Dr Priya Singh - Chair, NHS Frimley Integrated Care Board
r Catherine Butler - Housing Solutions Manager - Housing Services, Woking Borough Council)
* Cate Newnes-Smith - Chief Executive Officer, Surrey Youth Focus
* Rachel Crossley - Joint Executive Director - Public Service Reform, Surrey Heartlands ICS and Surrey County Council

In attendance
Gemma Morris - Detective Superintendent, Surrey Police

The Chairman welcomed the following new Board members:

- The two standing - no longer rotational - VCSE Alliance Co-Representatives attending alongside Jason Gaskell: Rosemarie Pardington (Director of Health, Research & Compliance/Deputy Chief Executive Officer, Young Epilepsy) and Sue Murphy (Chief Executive Officer, Catalyst).
- Jo Cogswell, Place Based Leader, Guildford and Waverley Health and Care Alliance; filling that Vacancy.

Rosemarie Pardington joined the meeting at 2.03 pm.

39/22 APOLOGIES FOR ABSENCE [Item 1]

Apologies were received from Fiona Edwards - Dr Priya Singh substituted, Jo Cogswell, Sinead Mooney, Siobhan Kennedy - Catherine Butler substituted, Karen Brimacombe, Professor Deborah Dunn-Walters, Jason Gaskell - Cate Newnes-Smith substituted, Professor Helen Rostill, Kate Barker, Liz Bruce - Rachel Crossley substituted.

40/22 MINUTES OF PREVIOUS MEETING: 28 SEPTEMBER 2022 [Item 2]

The minutes were agreed as a true record of the meeting.

41/22 DECLARATIONS OF INTEREST [Item 3]

There were none.

42/22 QUESTIONS AND PETITIONS [Item 4]

a Members' Questions

None received.

b Public Questions

None received.

c Petitions

There were none.

43/22 HEALTH AND WELLBEING STRATEGY HIGHLIGHT REPORT [Item 5]

Witnesses:

Mari Roberts-Wood - Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Liz Williams - Joint Strategic Commissioning Convener, Learning Disability and Autism and all age Mental Health, Surrey County Council and Surrey Heartlands ICS (Priority 2 Co-Sponsor)

Key points raised in the discussion:

Priority One

1. The Priority Three Sponsor in lieu of the Priority One Sponsor noted that:

- Progress had been made under the outcome: 'the needs of those experiencing multiple disadvantage are met', whereby the Changing Futures Lived Experience Group was meeting monthly and co-production work was being undertaken with those with lived experience.
- In addition to the information within the 'In the Spotlight - Uptake of Diabetes Prevention Programmes by Ethnically Diverse Communities' section: there was a stark difference in the likelihood of developing type 2 diabetes between people from white backgrounds and those from ethnically diverse communities; 3.8% of people from white backgrounds live with type 2 diabetes compared to 5% of people from ethnically diverse communities. People from ethnically diverse communities might also develop diabetes at a younger age than their white counterparts. Culturally appropriate interventions and co-designing were vital.

2. The Vice-Chairman recognised that there had been a huge success with the three pilots - Epsom, Woking and Staines - and wondered whether there was funding or an appetite for Active Surrey to roll that out more widely to other areas with a high number of ethnic minorities, depending on the population health data. She noted that it would be helpful to see the data to assess whether the people participating in the prevention programme maintain their average blood glucose levels and do not develop diabetes.
   - In response, the Priority Three Sponsor confirmed that the intention was for a wider roll out following the successes had, however funding was a challenge and discussions were underway. She would liaise with the contact at Active Surrey who might be able to provide the Board with an update on future plans for the particular programme. She agreed that tracking the outcomes were critical and she would look into the data.

Priority Three

3. The Priority Three Sponsor noted that:
   - £20,000 in funding had been awarded from the Police and Crime Commissioner for Surrey to a charity called the Skill Mill as set out under the third outcome; the outcomes would be tracked and it was hoped that it would make a difference to some people's lives.
   - In addition to the information within the 'In the Spotlight - Cost of Living' section: the borough and district councils, and Surrey County Council had been busy with partners to provide advice on support with energy bills and other utilities, facilitating Warm Hubs across Surrey and signposting to grants and delivering communications through a Surrey-wide leaflet; working collaboratively with the Voluntary, Community and Faith Sector (VCFS) to provide targeted support through food banks and debt advice for example and gathering local intelligence on the most vulnerable.
4. A Board member highlighted the Canal Watch (Woking) which was a problem-solving exercise involving a wide range of partners and volunteers; it had won the prestigious Tilley Award, the pre-eminent problem-solving award nationally and it meant that the partnership group goes forward to the international Herman Goldstein Award. He thanked all those involved as a real impact had been made.
5. The Chairman thanked the borough and district councils, and the Voluntary, Community and Social Enterprise (VCSE) Alliance for their work on addressing the cost of living, he reiterated that the leaflet sent to all households in Surrey provided signposting to support. He welcomed that the Government had provided funding for financial support over Christmas.

Priority Two

6. The Priority Two Co-Sponsor noted that:
   - The Mental Health: Prevention Oversight and Delivery Board (MHPODB) first met in October and it provided coordinated oversight of delivery integrating Priority Two of the Health and Wellbeing Strategy with the early intervention and prevention workstream of the Mental Health Improvement Plan (MHIP); it was pleasing to see that the approach aligned with the Integrated Care Strategies, focusing on prevention and the wider determinants of health.
   - In addition to the information within the 'In the Spotlight - CYP EHWB Questionnaire' section: the results of the 2022 Surrey Health Related Behaviour Questionnaire indicated a worrying 7% increase in the number of primary school children worrying about five or more issues and an increase of 3% of those worrying quite a lot or a lot about one issue. Secondary school students indicated a drop in percentage of both having access to an identified trusted adult and they had less happiness with life, it was striking that they indicated that they were worried about the mental health of someone in their family. It would be vital for the MHIP, the Mental Health Investment Fund (MHIF) and wider system partners to use those insights as well as the wider report findings to inform current and future delivery models.
7. A Board member asked whether there was evidence of a national trend that secondary school pupils felt a greater loss of access to a trusted adult, or whether it was a Surrey issue. He asked to what degree there was evidence to suggest the correlation between loss of access to a trusted adult and poor emotional health and wellbeing; whether it was a causal factor.
   - The Priority Two Co-Sponsor explained that she would liaise with the Public Health Lead on the matter, seeking further details particularly on the national picture, as it would be helpful for the system to understand that.
8. A Board member commented on the findings and connected them explicitly with some of the findings from other areas of research in the work underway in other partnerships, noting that the information reported was not surprising as all services were hearing that from children when they sought access to support and further help from Surrey's services and when they shared their views in their schools and other settings. She noted that it was important that the report and feedback reinforces what all knew as a priority for Children's Services and the Surrey Safeguarding Children Partnership. Alongside the Director of Public Health (SCC), she had introduced a recent session defining the future workshop for emotional wellbeing and mental health; she noted positive feedback from a young person who shared their lived experience on the issues faced locally, that the attendees were passionate about making a change and were listening. She commended the engagement work with Surrey's young people and hoped that all would continue to support it together.
9. The Vice-Chairman noted that the survey highlighted the significant need out there around early intervention and that needed to be a consideration when thinking about the impact of financial hardship on Surrey's providers and how that would be resolved as well as looking at the current offer for emotional health and wellbeing in schools. She asked whether any of the findings in the report would be reflected into the Joint Strategic Need Assessment (JSNA), especially the Core 20 PLUS 5 children and young people.
   - In response, a Board member noted that the survey was repeated every two years and whilst it was not nationwide there was comparative data

that she would put in the Teams meeting chat. She noted that when the JSNA chapter on Mental Health of children & young people was reproduced, various sources of data and information were signposted. The findings from the ongoing insight work would also feed into the Emotional Wellbeing and Mental Health Strategy, the Healthy Schools approach and the delivery of work within schools; she noted that it was an iterative process.

10. Given the current workforce issues and lack of provision which was exacerbating some of the issues reported in feedback from children in Surrey's schools, a Board member asked what the action plan was to reduce any deficits and whether the MHPODB's summary implementation plan which sought to align efforts, reduce duplication and ensure a common set of collaborative programmes to be prioritised; would be able to expose the need, the deficits and the actions that would be taken to address that.
    - In response, a Board member noted that the MHIP would seek to address those deficits and highlighted the challenge of the overwhelming level of need that exceeded the resources available to fully address those issues. Early intervention work was crucial, supporting children to feel better amongst themselves through their ordinary lives would reduce the demand. Going forward there was a need to map out a twin plan, addressing the need today in the short-term and addressing the need in the future in the long-term through strategic work to improve early intervention to reduce the source of the need; alongside the MHPODB, the Board would play a decisive role in terms of setting out that strategic work.

RESOLVED:

1. Noted progress against the three priorities of the Strategy in the Highlight Report.
2. Utilised the links to the refreshed Health and Well-being Strategy and Highlight Reports to increase awareness through their organisations and elicit support for reducing health inequalities.
3. Ensured members/member organisations were utilising the HWB Strategy engagement slide deck on the SCC Community Engagement sharepoint site to provide active leadership around the mission to reduce health inequalities within their own organisations and across the system.

Actions/further information to be provided:

Priority One

1. The Priority Three Sponsor will liaise with Charlotte Long at Active Surrey:
    - who might be able to provide the Board with an update on future plans for a wider roll out of the physical activities set up concerning the diabetes prevention programmes.
    - she would look into the data to track the outcomes to assess whether the people participating in the prevention programme maintain their average blood glucose levels and do not develop diabetes.

Priority Three

2. The Priority Two Co-Sponsor will liaise with Adam Letts, Public Health Lead (SCC) seeking further details on:
    - the national picture whether there was evidence of a national trend that secondary school pupils felt a greater loss of access to a trusted adult, or whether it was a Surrey issue.

- to what degree there was evidence to suggest the correlation between loss of access to a trusted adult and poor emotional health and wellbeing; whether it was a causal factor.

3. The Board member (Ruth Hutchinson) will put the comparative data around the survey which was repeated every two years - Health Related Behaviour Questionnaire - in the Teams meeting chat.

44/22 HEALTH AND WELLBEING BOARD COMMUNICATIONS PLAN 2023 [Item 6]

Witnesses:

Giselle Rothwell - Director of Communications and Engagement, Surrey Heartlands ICS
Sarah Archer - Communications Account Manager - Public Health, Surrey County Council

Key points raised in the discussion:

1. The Director of Communications and Engagement (Surrey Heartlands ICS) noted that:
   - The Board's Communications Group supported the Health and Wellbeing Strategy through a range of communications work, it was jointly chaired by her and the Strategic Director - Communications (SCC) and had a broad membership including representatives from the voluntary sector.
   - The Group had matured and evolved over the last couple of years, it was increasingly talking across Surrey with one voice across its partners; noting a joint campaign around mental health last year, the huge amount of work around Covid-19, and the current collaborative work on winter plans.
   - The Communications Plan 2023 had been refreshed to reflect the Board's revised Health and Wellbeing Strategy.
   - Greater value could be added as a Group through focusing on larger campaigns during the year, resourcing them well to deliver greater impact; rather than doing lots of smaller campaigns. The Group was always looking for new ways of evaluating communications campaigns.
2. The Communications Account Manager - Public Health (SCC) noted:
   - That the Plan which had been Covid-19 focused over the last two years, had been tweaked and expanded to focus on the Health and Wellbeing Strategy's priorities; whilst being flexible, reacting to health and wellbeing priorities as they change.
   - Areas of focus concerning Priority One included the: winter plan, children's immunisations including information on diphtheria and polio, promoting cancer screening and health checks, campaign around Stoptober, the Changing Futures Programme to reduce the stigma around people with multiple disadvantage; a new logo had been created.
   - Areas of focus concerning Priority Two included the: Face of Support campaign last year concerning early intervention, building resilience and connecting people in communities and working with the Community Champions to disseminate messages, using case studies to highlight lived experience and using mental health workers in a recent campaign.
   - Areas of focus concerning Priority Three included the: aforementioned Surrey-wide leaflet and there had been requests for that leaflet to go much wider, campaign about domestic abuse highlighting the coercive

and controlling behaviours, work underway with other directorates around Active Travel which provided health benefits.

- The Tactics and Channels, Opportunities and milestones, Key Audiences, and Success sections in Annex 1.

3. A Board member noted that she fully endorsed the focus on a few campaigns a year and she encouraged the Group to look at the Food Strategy under development - under Priority One - which cut across a number of the key themes discussed such as the cost of living, sustainability and the health impact of diet; it would be useful to use those insights.
    - In response, the Director of Communications and Engagement (Surrey Heartlands ICS) would take that suggestion to the Group's next meeting.
4. A Board member asked whether there was sufficient linkage into the VCFS groups and priority populations and whether there was anything more that could be done to support that. As had been highlighted by the Covid-19 communications campaigns it was vital to get that culturally aware messaging out; whilst delivery was important so was co-designing messages which she felt was missing. As there was no additional budget allocated to that, she asked whether there were concerns around delivery and whether the VCSE Alliance could help the Group to get closer to some of those groups and priority populations.
    - In response, the Director of Communications and Engagement (Surrey Heartlands ICS) acknowledged that there was always more that the Group could do, she noted that the work underway with Healthwatch Surrey and the wider sector was critical in delivering the Plan through reaching out into local communities. She noted that it was positive that a few communications officers from across the VCFS groups were members of the Group and she welcomed the offer regarding the Group linking into the VCSE Alliance and the voice group to help them do that.
5. A Board member noted the impressive range of campaigns and channels that were used to access as many residents as possible. Regarding the GP texting service which was a trusted means of communicating with residents - a letter alternative to those not digitally connected - and was one of the most extensive databases available in Surrey, she asked how that could be expanded to circulate some of the preventative and wider messages potentially including social care support from across agencies without devaluing that trusted source.
    - In response, the Director of Communications and Engagement (Surrey Heartlands ICS) noted that it was a valuable channel and that the Group had to be careful about how it used it so that it does not dilute it and there was a cost involved. The Group worked closely with the primary care teams in health to think about when a cascade might be useful such as during Covid-19. She noted that Group would look to explore the cascading of those health prevention messages through the GP texting service.
6. Referring to Priority Three, area of focus: community-led action, looking ahead to the work around priority populations a Board member wondered whether the concept of neighbourliness could be pursued as it helped to cut across several of the priorities as a well-informed neighbour may be able to support somebody with their mental health or to keep safe. He noted the Emoji Awareness campaign which was launched last week, which was under the area of focus concerning safeguarding and exploitation, he encouraged Board members to look at that and he would send the link to the Committee Manager (SCC).
    - In response, the Director of Communications and Engagement (Surrey Heartlands ICS) noted that the Group would like to know more about the

Emoji Awareness campaign and she agreed that it should explore all those avenues of neighbourliness, working in partnership. She noted that there was much potential as there were many channels available, resourcing and the time to pursue those was a consideration.

7. The Vice-Chairman noted that a positive about Surrey Heartlands ICS was that primary care were all on a similar website and she would be happy to work more closely with Director of Communications and Engagement (Surrey Heartlands ICS) as she believed that primary care would be willing to share a communications campaign on their social media platforms, as the websites were cluttered; it would be useful to work on having a more aligned social media communications campaign.
    - In response, the Director of Communications and Engagement (Surrey Heartlands ICS) noted that she was working with a company called Redmoor Health with primary care colleagues, who were supporting general practices to get their social media up and running. The Group was looking at circulating consistent messaging through primary care's social media; she would liaise with the Vice-Chairman on her offer of support.

RESOLVED:

1. Noted the alignment of the Communications Plan with the refreshed HWB Strategy and the stronger links between the Communications Plan priorities and the HWB Strategy outcomes.
2. Approved the refreshed Communications Plan for 2023.
3. Shared and endorsed the priorities within members' respective organisations.
4. Ensured representation on HWB Communications group.
5. Considered appetite and capacity for considering allocated money or formally pooled budgets for the Communications Plan.

Actions/further information to be provided:

1. The Director of Communications and Engagement (Surrey Heartlands ICS) will take that suggestion to the Communications Group's next meeting to look into the Food Strategy.
2. The Director of Communications and Engagement (Surrey Heartlands ICS) will follow up the offer with the Board member (Kate Scribbins) for the Communications Group to link into the VCSE Alliance and the voice group to help them to link into the VCFS groups and priority populations on delivery and co-designing messaging including culturally aware messaging.
3. The Director of Communications and Engagement (Surrey Heartlands ICS) via the communications Group, will look to explore the cascading of those health prevention messages through the GP texting service; without devaluing that trusted source.
4. The Board member (Gavin Stephens) will send the link to the Emoji Awareness campaign to the Committee Manager (SCC) to be circulated to the Board.
5. The Director of Communications and Engagement (Surrey Heartlands ICS) via the Communications Group, will look into the Emoji Awareness campaign and the suggestion to explore all those avenues of neighbourliness, working in partnership.
6. The Director of Communications and Engagement (Surrey Heartlands ICS) will liaise with the Vice-Chairman following up her offer of support around working more closely on having a more aligned social media communications campaign and sharing those campaigns on their social media platforms.

45/22 EMPOWERED AND THRIVING COMMUNITIES - SYSTEM CAPABILITY UPDATE [Item 7]

Witnesses:

Daniel Shurlock - Design Lead for Empowered and Thriving Communities, Surrey County Council
Mari Roberts-Wood - Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
Dr Gillian Orrow, Co-Founder of Growing Health Together, Programme Director and Healthy Horley PCN Lead
Dr Beccy Bowden - Chief Executive Officer, Community Foundation for Surrey

Key points raised in the discussion:

1. The Design Lead for Empowered and Thriving Communities (SCC) noted that:
   - When the Health and Wellbeing Strategy was first refreshed with the goal to narrow health inequalities, there was a commitment to review how the system was working alongside communities and the identified Key Neighbourhoods were prioritised as they had the poorest health outcomes.
   - There were some fantastic examples across the system to be proud of in terms of building on learning and connecting more closely with communities; that work was being shared and done in a way that was understandable.
   - That engagement, listening and understanding of what was going on in Surrey's communities, could be applied to other work and more needed to be done; looking at investment into community-led action for example, through various funds such as Your Fund Surrey and the MHIF.
2. The Priority Three Sponsor provided an example of the joint work in Merstham:
   - Merstham was the most deprived area in Surrey, looking at the 21 Key Neighbourhoods it had some of the most concentrated challenges. Reigate and Banstead Borough Council had been investing in community development work within Merstham for the past fifteen years. She encouraged Board members to visit the Merstham Community Hub - including a library and a community café - which was resultant from the engagement and co-design work with residents and it was supported by volunteers; it had played a key role during Covid-19.
3. The Co-Founder of Growing Health Together, Programme Director and Healthy Horley PCN Lead provided an example of Health Creation in East Surrey:
   - Health Creation had been game changing for East Surrey through Growing Health Together, which developed key working relationships with Surrey County Council and Reigate and Banstead Borough Council's Community development team, building on the fantastic work that Reigate and Banstead Borough Council had been developing over the past fifteen years. Focused Health Creation work was undertaken in Nailsworth Crescent housing estate in Merstham, through engagement and listening the residents highlighted their priorities which included improving the quality of their housing, improving the social provision for young parents and their families, and improving the local environment in

terms of green spaces and air quality. Through partnership work the various sectors worked alongside local people to affect the changes requested by the community, evidence from elsewhere in the country suggested that approach could catalyse significant and sustained reversal of even entrenched health inequalities.

4. The Chief Executive Officer (Community Foundation for Surrey) provided an example of future investment opportunities:
   - The Community Foundation for Surrey (CFS) was established in 2005 and its mission statement was to grow philanthropy to change the lives of local people for the better, using donors' money to make the most impact over the long-term, bringing together key people and organisations. Over the last three years the CFS had £4 million worth of grants out in the first few months of 2020; and so far it had awarded over £20 million into Surrey, focusing only on local charities and community organisations, and it had generated over £37 million in endowed funds. The £17 million of invested funds were split into 89 different funds for a particular cause or area, each was run by a panel of local volunteers. The CFS sought to change the narrative, particularly in those Key Neighbourhoods to focus on the huge resources that were available in Surrey. She noted the grant awarded to the Merstham Community Hub to grow and develop their business. She noted that the CFS sought to use the 16 area funds to build capacity in local communities, for example Guildford Philanthropy was set up in 2014; over £1 million had been raised for the area. She noted that it would be good to engage people more to help them to manage that investment.
5. The Design Lead for Empowered and Thriving Communities (SCC) concluded that the report set out the commitment to the work and the need to engage and understand Surrey's communities in terms of data and insights and how that informed the commissions and service designs. Going forward, it would be vital to undertake that capacity building, local listening and looking longer-term concerning how the system could leverage other types of investment into community action, looking at the detail through working in partnership.
6. The Chairman noted that the work would align with the towns and villages initiative, with the detail to follow early next year.

RESOLVED:

1. Noted the progress to date, examples and key reflections from efforts to work more creatively and collaboratively alongside communities.
2. Confirmed that the development of the Empowered and Thriving Communities system capability be further embedded into ways of working right across the Surrey system, with a priority focus on partnership work alongside communities in the 21 Key Neighbourhoods.
3. Agreed that over the next 12 months there will be a focus on specific actions for (i) strategic direction and alignment (ii) data and insights (iii) capacity building (iv) investment.

Actions/further information to be provided:

None.

46/22 SURREY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2021/22 [Item 8]

Witnesses:

Simon Turpitt - Independent Chair, Surrey Safeguarding Adults Board

Key points raised in the discussion:

1. The Independent Chair (SSAB) noted that:
   - There had been an increase in concerns raised which had turned into an increase in Section 42s.
   - The upward trend had continued concerning Safeguarding Adults Reviews from six in the previous year, last year there were 14, and this year there were 26; that was comparatively high as throughout his time in Surrey there only used to be a few a year. Covid-19 and the resultant backlog was a partial explanation for the increase, there was a lot of pressure on people around mental health, as well as instances of alcohol and drug abuse.
   - Prevention was good however it was vital to understand the underlying causes, seeing those clearly was difficult by the time the cases reached the SSAB however there was better data and more information available.
   - The world had moved on since the Annual Report was published, worries looking ahead were staffing: recruitment and retention, especially around the areas in the voluntary sector predominantly which were being put under enormous pressure, the financial environment, care homes and domiciliary care, capacity in social care and the NHS; and the rise of mental ill health particularly around those who had never presented before and in children, and an increase in needs related to autism.
   - It was vital that all understood what safeguarding means, how to manage issues and how to provide support, ensuring that vulnerable residents are looked after.
   - The support from all agencies had been immense and critical for the SSAB, he noted his thanks.
2. The Chairman noted that the report had been reviewed through other parts of the system and acknowledged the challenges ahead with the increased reviews.
3. The Chairman thanked the Independent Chair (SSAB) for all the work undertaken over the past year. He noted that it was likely to be Simon Turpitt's final meeting as the Independent Chair (SSAB) with his successor to be in post early January and on behalf of the Board he thanked him for his hard work in chairing the SSAB over a significant number of years.

RESOLVED:

1. Considered and noted the Surrey Safeguarding Adults Board Annual Report 2021/22.
2. Considered the SSAB Annual Report in relation to the HWB strategic priorities to ensure collaborative working between the Boards.

Actions/further information to be provided:

None.

47/22 SURREY SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2021/2022 [Item 9]

Witnesses:

2

Alison Cutler - Partnership Development Manager, Surrey Safeguarding Children Partnership
Simon Hart - Independent Chair, Surrey Safeguarding Children Partnership

Key points raised in the discussion:

1. The Partnership Development Manager (SSCP) noted that:
    - In 2018 the Working Together guidance was published by the Government whereby the responsibility for safeguarding arrangements shifted primarily from the Safeguarding Children Board to the Safeguarding Children Partnership and more substantially, the responsibility shifted to three partners: health, police and the local authority.
    - As part of those new arrangements, the requirement was that those statutory partners produce an Annual Report outlining the activity and impact of the SSCP and that report is then scrutinised by the Independent Chair (SSCP).
    - Some of the activity from last year focused on learning and improvement, examples highlighted how the learning from reviews was used to move forward practice across the partnership; mental health was a focus area.
    - The SSCP undertook audits for partners to look at how they were managing safeguarding practices within their organisations and over the past year there had been some large improvements there.
    - The SSCP continued to focus on early help and thresholds, that was progressing well but was an area to be looked at in the coming year.
    - Adolescent resilience and support, including emotional health and wellbeing continued to be a focus and one of the highlights in the report was the formation of the Mental Health Alliance and the impact that had in providing better support to schools through their primary health workers.
    - Neglect remained a big issue and that came up in Serious Case Reviews and national child safeguarding practice reviews, the SSCP was continuing its work around Graded Care Profile roll out across Surrey.
    - Three of the challenges that the SSCP was looking at in the months ahead were: a greater consistency in the quality and effectiveness of multi-agency safeguarding practice and involvement in child protection processes, learning lessons from the reviews and identifying areas where it could improve, and the issues of recruitment and retention which were issues nationally but needed to be monitored in Surrey.
2. The Independent Chair (SSCP) noted that:
    - His role was to make an objective and independent comment on the Annual Report, which he strongly supported explaining that the governance arrangements that were in place had become well established.
    - The SSCP was well supported by the partners both from the point of view of maintaining the stability of the funding arrangements, but also the amount of time that agencies were committing to the SSCP.
    - The newly added section on the inspectorates' findings was an additional strength.
    - The section dealing with recruitment and retention was highly appropriate and it would continue to be one of the major challenges to safeguarding in Surrey, as it was nationally.

- Other challenges to safeguarding were: the growing gap between levels of need and capacity which was a significant potential risk, emotional wellbeing and mental health particularly concerning adolescents and the SSCP had undertaken important work in relation to adolescent suicide and it had been influential in helping to drive some of the transformational change that was taking place in Surrey; the consistency in practice whilst developing, remained an element of risk alongside pace and consolidation.
- Not mentioned in his report, was that the SSCP had looked carefully at the implications of Covid-19 over the course of the last eighteen months. Just as the SSCP had reached the point where it seemed as though all the local arrangements were in place and functioning, a potential risk to safeguarding was the challenges associated with cost of living and families being able to sustain themselves financially in very difficult circumstances.
- Supported the conclusions reached by the statutory partners about progress being made, whilst being cautious about the sustainability.

3. The Chairman read out a comment in the Teams meeting chat by a Board member which he endorsed: that he had joined the children's safeguarding team several times this year and he noted that he was impressed with the working relationships, the lack of hierarchy and the empathy and care that was shown by all partners when carrying out reviews.
4. The Chairman thanked the Partnership Development Manager (SSCP) and Independent Chair (SSCP) for all the work undertaken over the past year.

RESOLVED:

1. Noted the report.
2. Noted the SSCP's priorities for 2022 to 2023.
3. Noted the need to focus on the impact of activity, of improving the quality of SSCP's work with children and families and being able to evidence improvements in the lived experience for children.

Actions/further information to be provided:

None.

48/22 NATIONAL HOSPITAL DISCHARGE FUNDING [Item 10]

Witnesses

Lucy Clements - Health Integration Policy Lead, Surrey County Council and Surrey Heartlands ICS

Key points raised in the discussion:

1. The Chairman noted that Surrey received £8.5 million through the Better Care Fund and it had to make a submission to the Government within the tight deadline of 16 December 2022, which it had done.
2. The Health Integration Policy Lead (SCC and Surrey Heartlands ICS) noted that the report outlined the allocation coming to Surrey and what the proposals were for spending that money as a Surrey system, both Surrey Heartlands and Frimley ICSs.

3. A Board member thanked the team as the timescale for submission was very tight. She noted that it was a good joint piece of work and reiterated that it was important for the Board to have greater scrutiny over the Better Care Fund submission and to look at the governance around that, particularly as there was even more money coming in through the Better Care Fund.
    - The Chairman agreed that it was a good collaborative piece of work, some of that information had been shared with Government ministers who were keen to see how the money could be used to free up beds. He agreed that the Board needed to have more involvement in the Better Care Fund process and how the money is spent before being asked to sign it off, sometimes retrospectively.

RESOLVED:

1. Approved that Discharge to Assess (D2A) would be the priority scheme funded from this grant c£6.5m.
2. Approved that any remaining monies once D2A has been funded, c£2m, would be spent on the priority cohorts of Mental Health, Self-Funders and P3 placements (outside of D2A), subject to a business case and agreement at ICS Execs.
3. Approved that if Surrey Heartlands or Frimley develop a funding gap on D2A as the year progresses, the use of this £2m would be reviewed and potentially re-prioritised.

Actions/further information to be provided:

1. The Health Integration Policy Lead (SCC and Surrey Heartlands ICS) will follow up the Board member's (Claire Fuller) and Chairman's comments that the Board needed to have greater scrutiny over the Better Care Fund submission and involvement in the process going forward and to look at the governance around that such as how the money is spent before being asked to sign it off, sometimes retrospectively, particularly as there was even more money coming in through the Better Care Fund.

49/22 INTEGRATED CARE SYSTEMS (ICS) UPDATE [Item 11]

Witnesses

Dr Priya Singh - Chair, NHS Frimley Integrated Care Board
Tom Lawlor - Director of Operations, Surrey Heath, Frimley ICS
Professor Claire Fuller - Chief Executive Officer, Surrey Heartlands ICS

Key points raised in the discussion:

1. The Chair (NHS Frimley ICB) noted that:
    - The Frimley ICS was in the process of re-examining and refining the Integrated Care Strategy, the work to align to that and to ensure delivery had been well supported across the system.
    - There was an understandable general anxiety in society and that fed into the way in which pressures were being felt across the public services, however reflecting on the work that had been done with the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) the way in which the workforce was rising to the challenges regardless of the pressures was commendable, for example the preparation around winter planning.

- There were additional pressures now of Strep A for example, however people across the system were working constructively together and she thanked the public service partners and the teams.
- The work that the ICP had been doing was focused on creating key priorities, ensuring clarity and the alignment around that; an example of work underway included fuel poverty and being able to have actionable insight from that population health data.

2. The Director of Operations (Surrey Heath, Frimley ICS) noted that:
   - In terms of the implementation of the Fuller Stocktake report and the next steps for primary care, the recommendations were aligned with Frimley ICS's goals and so had been built into the existing work within the system.
   - The Frimley ICS had adopted that population health management approach and used that to aid and improve access to services and to improve the appropriate continuity of care. There had been a focus on understanding the population and different cohorts and then providing the right pathways and care for those people.
   - Within its neighbourhoods there were existing integrated care teams and the Frimley ICS had used those to evolve and refine what it was doing based on the needs of a particular neighbourhood such as looking at care navigation, using the multi-disciplinary teams ensuring proactive and reactive care for people, providing same-day access and tailoring that provision, and using the insights and data throughout the connected care system to highlight opportunities and areas for improvement.
   - The Frimley ICS sought to work with its communities to make the changes needed and that had been one of the big differences and changes in terms of the method and how the system works with people.
3. The Chief Executive Officer (Surrey Heartlands ICS) noted that:
   - The Surrey Heartlands ICS had declared a system-wide critical incident yesterday, which reflected the high levels of system pressures and demands in part linked to the number of different infections circulating.
   - It was important for the system to ensure that it continued to focus on transformation and making those longer-term changes, so that it does not simply remain reactive.
   - The system took its Fuller Stocktake report implementation plans through its last ICB, looking at the three themes: how to improve access for people, how to improve continuity to look after the most complex patients, and how to better improve health inequalities with communities.
   - The other areas that were important to consider were the enablers: estates, data, digital, workforce and leadership.
   - There would be a meeting of the ICP following the Board where the ICP would be signing off its Integrated Care Strategy which aligned to the long-standing Health and Wellbeing Strategy, its priorities and the wider determinants of health.
4. The Chairman noted that he and the Chief Executive Officer (Surrey Heartlands ICS) were supporting the Rt Hon Patricia Hewitt with her review of the ICSs nationally, and that reinforced the strong local leadership and partnership working that there was in Surrey Heartlands and Frimley; compared to other parts of the country. He noted that it would be interesting to see what the Hewitt review recommends and commented that there were not any ideas or better ways of working that Surrey was not already implementing locally. As two systems, Surrey was leading the charge around engaging with its communities and improving health outcomes for its residents.

2

RESOLVED:

1. Noted the update provided on the recent activity within the Surrey Heartlands and Frimley Integrated Care Systems (ICS) regarding the Integrated Care Partnerships and Integrated Care Boards.
2. Noted the verbal update provided on both the Surrey Heartlands ICS' and the Frimley ICS' implementation of the 'Next steps for integrating primary care: Fuller stocktake report'.

Actions/further information to be provided:

None.

50/22 DATE OF THE NEXT MEETING [Item 12]

The date of the next public meeting was noted as 15 March 2023.

The Chairman thanked all for their engagement and contributions over the past year and whilst he feared that the next six months would be challenging, he provided reassurance that the system would step up and carry on as it had done over the past year. He wished all a Happy Christmas and a peaceful New Year.

Meeting ended at: 3.34 pm

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Chairman

Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Health and Wellbeing Strategy Highlight Report
HWBS Priority populations:	All
Priority 1, 2, 3:	All
Outcome(s)/System Capability:	All
Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	Helen Johnson, Senior Policy and Programme Manager - Health and Wellbeing, Surrey County Council; Helen.Johnson1@surreycc.gov.uk
Board Sponsor(s):	• Karen Brimacombe, Chief Executive, Mole Valley District Council (Priority 1 Sponsor) • Professor Helen Rostill, Deputy Chief Executive and Director of Therapies, Surrey and Borders Partnership/Director for Mental Health, Surrey Heartlands ICS and SRO for Mental Health, Frimley ICS; Kate Barker and Liz Williams SCC/Surrey Heartlands Joint Conveners (Priority 2 Sponsors) • Mari Roberts-Wood (Priority 3 Sponsor), Managing Director, Reigate and Banstead Borough Council
HWB meeting date:	15 March 2023
Related HWB papers:	Item 8 - ICS' Update
Annexes/Appendices	• Annex 1 - Highlight Report including JSNA progress and Communications Update • Annex 2 - DRAFT Frimley Health and Care Integrated Care Strategy – 'Creating Healthier Communities'

5

2. Executive summary

This paper provides an overview of the progress of local shared projects and communications activity supporting delivery of the Health and Wellbeing Strategy (HWB Strategy) in the priority populations as of 21 February 2023. The Highlight Report provides an overview of each HWB Strategy Priority, describes what has been achieved in the previous period against outcomes and how collaborative working has aided this progress. It also has a section on communication activity associated with the HWB Strategy's priority populations and priorities and a section on the progress of the review of the Joint Strategic Needs Assessment (JSNA) – chapters already published/in development. The Communications Update completes the Highlight Report.

Alongside the above, there are details of a survey that will go to all Board members, a recent paper that went to Surrey Heartland Integrated Care Partnership regarding the addition of a spatial layer of Towns to the existing layers (including HWB Strategy Key Neighbourhoods) to improve partnership working and a request from the Empowered and Thriving Communities system capability lead, Marie Snelling (SCC) are also covered.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note progress of the Strategy in the Highlight Report.
2. Utilise the links to the refreshed Health and Well-being Strategy and Highlight Reports to increase awareness through their organisations and elicit support for reducing health inequalities.
3. Ensure member organisations are utilising the HWB Strategy engagement slide deck on the SCC Community Engagement sharepoint site to provide active leadership around the mission to reduce health inequalities within their own organisations and across the system.
4. Undertake to complete the Health and Wellbeing Board/Strategy Delivery review survey by the deadline of **24 March 2023.**
5. Note the consideration of the Towns as a spatial layer for partnership working to reduce health inequalities by the Surrey Heartlands Integrated Care Partnership.
6. Agree the proposal by the Health and Wellbeing Strategy's System Capability Lead for Empowered & Thriving Communities (Marie Snelling, Executive Director Customer & Communities, Surrey County Council) that Dr Gillian Orrow (Growing Health Together Director in East Surrey & GP) takes on the role of clinical lead for the Empowered and Thriving Communities system capability.

4. Detail

For Priority One a focus is given in the Highlight Report to the evaluation of the Bridge the Gap Alliance's programme that provides a specialist trauma informed model of outreach for adults with multiple disadvantage. Improved outcomes were demonstrated for 70% of female participants and 100% of male participants. It is

estimated that investing £1.2m/year to maintain services for 60 clients has the potential to save the system £1.35m/year.

The national Changing Futures funding for this transformational work in Surrey is due to end in March 2024. Sources of longer-term core funding and short-term innovative funding options are being sought. The programme is requesting support from organisations to achieve this. For more information, contact Collette Le Van-Gilroy at collette.levangilroy@surreycc.gov.uk or Lisa Byrne at lisa.byrne1@surreycc.gov.uk.

For Priority Two a focus is given to the results of the Surrey Children's Services and Coram Voice research into looked after children and care leavers - on their lives and experiences in care, and what is important to them.

Among the areas for improvement were that looked after children would like to see their family more. Not all children stated that they had at least 'one really good friend' and they felt stigmas associated with being in care. Life satisfaction for care leavers was lower than for the general population, with barriers of money, location and their mental health. They also find it more difficult to cope financially than their peers. An action plan is in development and will come to the Health and Wellbeing Board. For more information, contact Elaine Andrews at elaine.andrews@surreycc.gov.uk.

For Priority Three a focus is given to Frimley Health and Care which has received just under £100,000 from Health Education England to develop a programme to understand its communities better so that it can target what needs to change to make health and care jobs more attractive and accessible to local people. It will draw key stakeholders together, including SCC Economy and Growth/Public Health teams and Department of Work and Pensions, at a workshop to develop a logic model for the programme in March.

The intention is to share best practice and create momentum regarding the benefits of working with anchor institutions. There is also a commitment to sharing progress with other health and care systems, particularly those within the NHS South East area. For more information, contact Sandra Grant at sandra.grant19@nhs.net.

Other developments of note are the draft Frimley Integrated Care Strategy – 'Creating Healthier Communities' (see Annex 2) and the publication of Surrey Heartlands Integrated Care Strategy – see Our strategy - ICS (surreyheartlands.org) and Joining up care across Surrey Heartlands - YouTube.

See Highlight Report at Annex 1.

Review of the Health and Wellbeing Board/Strategy Delivery

A survey has been developed for Board members to help collectively assess the effectiveness and function of the Health and Wellbeing Board. It also asks the Board's constituent organisations' perspective on the Surrey system's current efficacy, utilising the assessment that was conducted at the Health in All Policies Workshop in March 2022 as a baseline. The link to the survey - in a private part of

the SCC Surrey Says website - has been circulated via email to Board members. It should be completed before Close of Business (COB) on Friday 24 March.

5

Towns as a spatial layer

The Surrey Heartlands Integrated Care Partnership received a paper in February on the development of Towns as another spatial layer of focus for ongoing activity in reducing Health Inequalities.

The report set out the case for using a towns footprint for enhanced partnership work addressing priorities in individual localities, including reducing health inequalities, improving equality of opportunity and access to services, the difference in life expectancy, community engagement, all of which are known key issues and require a multi-agency, system approach.

Good local working relationships and partnership work has already been developed and is underway in a number of towns (e.g. Caterham, Farnham, Weybridge, Staines and Horley) and another ten have been identified for future consideration in 2023 in a staged approach (with other towns to be determined):

- Addlestone
- Ashford
- Chertsey
- Leatherhead
- Sunbury
- Banstead
- Egham
- Haslemere
- Walton
  West Byfleet

	D&B	Town	Pop'n	HWB Areas of IMD		Place Alliance	Surrey Heartlands PCN
1	GBC	Guildford	81,100	Westborough	Stoke Ash Wharf*	Guildford & Waverley	GRIPC/ East Guildford
2	WBC	Woking	75,200	Canalside	Goldsworth Park	North West	WISE1/2/3
3	E&EBC	Epsom	35,500	Court	Tattenham Corner	Surrey Downs	Epsom/ ICP
4	SHBC	Camberley/Frimley	25,050	Old Dean		Surrey Health*	
5	RBBC	Redhill	33,125	Merstham, Hooley	Redhill West	East Surrey	Redhill Phoenix/Care Collaborative
6	SBC	Sunbury-on-Thames	30,375			North West	SASSE1
7	EBC	Walton-on-Thames	25,850	Walton South		North West	WPC/WHAM
8	SBC	Ashford	24,800	Ashford North		North West	SASSE2/3
9	RBC	Egham	24,250	Englefield Gr*		North West	SASSE2
10	RBBC	Horley	23,375	Horley Central		East Surrey	Healthy Horley
11	RBBC	Reigate	22,575			East Surrey	Redhill Phoenix/Care Collaborative
12	TDC	Caterham	21,775			East Surrey	North Tandridge
13	WaBC	Farnham	20,500	Upper Hale		NE Hants/Farnham*	
14	WaBC	Godalming	20,225	Godalming Central		Guildford & Waverley	East Waverley/ West of Waverley
15	SBC	West Byfleet	19,325			North West	WBC
16	RBC	Addlestone	18,675			North West	Coco
17	EBC	Weybridge	17,500			North West	WHAM
18	SBC	Staines	16,125	Stanwell N	St'well N 001B St'well N 001C	North West	SASSE2/3
19	RBBC	Banstead	15,200			Surrey Downs	Banstead
20	RBC	Chertsey	14,975	Chertsey St Anne's		North West	Coco
21	MVDC	Leatherhead	13,975			Surrey Downs	Leatherhead
22	MVDC	Dorking	13,425	Holmwoods		Surrey Downs	Dorking
23	WaBC	Cranleigh & villages	11,675			Guildford & Waverley	East Waverley
24	EBC	Esher	11,525			Surrey Downs	East Elmbridge
25	EBC	Cobham	10,625			Surrey Downs	Leatherhead
26	WaBC	Haslemere	10,025			Guildford & Waverley	South Tandridge
27	TDC	Oxted	9,600			East Surrey	South Tandridge
28	TDC	Lingfield & villages	??			East Surrey	West Waverley
29	MVDC	Newdigate & villages	??			Surrey Downs	Dorking

* = Frimley ICS

(Town populations above are calculated based on the number of residents living within a 25-minute walking distance from a central point in the town's retail centre)

The identified towns align to the Key Neighbourhoods as per the above.

Empowered and Thriving Communities system capability

On 21 December 2022 the Health and Wellbeing Board reviewed a full update on the Empowered and Thriving Communities System Capability (see Item 7 - Empowered and Thriving Communities - System Capability Update.pdf (surreycc.gov.uk). The Board recognised the progress made to date, confirmed that the system capability be further embedded into ways of working right across the Surrey system (with a priority focus on partnership work alongside communities in the 21 Key Neighbourhoods), and agreed specific actions for the next year on (i) strategic alignment (ii) data and insights (iii) capacity building and (iv) investment.

In order to progress this agenda, the Board's System Capability Lead for Empowered & Thriving Communities (Marie Snelling, Executive Director Customer & Communities, Surrey County Council) proposes that Dr Gillian Orrow (Growing Health Together Director in East Surrey & GP) takes on the role of clinical lead for the Empowered and Thriving Communities system capability - this reflects positive joint working already underway and enables Dr Orrow to co-convene (with Dan Shurlock, (Strategic Lead Customer & Communities, SCC) a Surrey-wide learning network to further grow and practically embed the HWB Strategy Principles for Working with Communities.

5. Opportunities/Challenges

- Implementation plans with risk ratings (subject to ongoing review and refresh) continue to sit behind the Highlight Report, with risks escalated to the Board as necessary.
- A review of the Health and Wellbeing Board/Strategy Delivery by Board members will inform a revised Terms of Reference, assist in the development of the Forward Plan for Board meetings and potentially offer insights into more effective delivery of the HWB Strategy.
- The exploration of Towns as a useful spatial vehicle offers new opportunities for partnership working.
- The development of the Empowered and Thriving Communities system capability continues, with Dr Gillian Orrow to co-convene (with Dan Shurlock, Strategic Lead Customer & Communities, SCC) a new learning network.

6. What communications and engagement happened/needs to happen?

- All Board members are requested to share the Highlight Report widely within their respective organisations and utilise the HWB Strategy engagement slides as appropriate.
- The Health and Wellbeing Board's Communications Group will meet in March to consider the implementation of the new Communications Plan, presented to the Board at the December meeting.

7. Next steps

- The Highlight Report continues to be reoriented to reflect the programmes and projects that form part of the refreshed Implementation Plans and is available on this Healthy Surrey web page.

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Annex 1

Health and Wellbeing Strategy: Priority 1 – Supporting People Live Healthy Lives

IMPACT SUMMARY **Improved physical health through the prevention of physical ill-health and the promotion of physical well-being**	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?	DATA, INSIGHTS AND CHALLENGES – CHILDREN & YOUNG PEOPLE'S ACTIVE LIVES SURVEY
OUTCOMES By 2030: • People have a healthy weight and are active • Substance misuse is low (drugs/alcohol & smoking) • The needs of those experiencing multiple disadvantages are met • Serious conditions and diseases are prevented • People are supported to live well independently for as long as possible **WHO IS LEADING THIS?** **Priority sponsor:** Karen Brimacombe. Chief Executive, Mole Valley District Council **Programme Manager:** Jason Ralphs, Policy and Programme Manager, Surrey County Council For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind. In light of the Community Vision and the vital role, communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey's priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support. It also outlines how we need to collaborate so we can drive these improvements, with communities leading the way. Priority 1 currently focuses on enabling residents to lead physically healthier lives. This priority area is focused on prevention, removing barriers and supporting people to become proactive in improving their physical health. Priority 1 programmes include those which focus on: • Working to reduce obesity, excess weight rates and low levels of physical inactivity • Supporting prevention and treatment of substance misuse, including alcohol, and smoking cessation. • Ensuring that the needs of those experiencing multiple disadvantages are met. • Promoting prevention to decrease incidence of serious conditions/diseases • Living independently and dying well	A multi-agency steering group to support the delivery of the NHS LTP **Tobacco Control programme** has been established with leadership from the Surrey Heartlands ICB respiratory clinical lead. All acute trusts in Surrey will be required to offer stop smoking services to inpatients once the services are implemented, the model will be adapted for maternity patients and patients in mental health inpatient settings. Patients will also be supported with their quit attempts in the community following discharge from hospital. Collaborative working between public health, Trading Standards and Environmental Health is underway to review the **Eat Out, Eat Well** programme, with the development of a questionnaire to share with food vendors across Surrey. The aim of the scheme is to reward restaurants, takeaways and other food businesses that make it easier for their customers to make healthy choices. Active Surrey hosted **'Movement for Change: 1 year on'** looking at challenges and successes a year into delivery of the strategy. Over 120 people attended the event from across the system, which focused on physically active communities and reducing health inequalities. A strategy workshop on the **Better Care Fund** (BCF) was held on Thursday 2 March. The aims of the workshop were to explore ideas and challenges for BCF spend in 2023/24; to present key findings from recent review; to hold an initial discussion on the BCF longer term plans.	The latest Children & Young People's Active Lives survey produced by Sport England shows that 48.9% of Surrey's under 16's met the Chief Medical Offer's recommendation of 60 minutes activity every day. But whereas figures for England show a return to pre-pandemic levels (47.2% are active nationally), Surrey is still short of hitting its 2018/19 peak, when 53.3% of children were active. Although the data showed an increase in children being active, old disparities remain. National figures show: • Girls are less active than boys (45% nationally vs 50%), though there's been an increase in secondary participation • Black and Asian children are less active than fellow white pupils (both 41%, vs 50%) • Young people from less affluent households are 10% less active than most affluent areas (42% vs 52%) The report demonstrates the link between activity levels, physical and mental health outcomes. Children who enjoy taking part in sport typically move more and report being happier, with increased resilience and a greater sense of community. Commenting on the results, Active Surrey Managing Director Lil Duggan said: "It's great to see the work put in by schools, sports clubs and parents to encourage children back into healthy habits is paying off. We hope that next year we'll see further growth in the number of young people in Surrey meeting the recommended guideline…The team at Active Surrey are particularly focussed on helping those young people who have the most to gain from moving more but are sometimes the least able to access organised activities. As the cost-of-living squeeze deepens, we'll continue our work to ensure all children have a chance to enjoy a healthier, happier future." For more information contact: lawrie.baker@surreycc.gov.uk

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 1 OUTCOMES?

People have healthy weight and are active

- Active Surrey has secured £80K investment from the Office of the Police and Crime Commissioner to expand Friday Night Projects and Step Out to Step In programmes.
- The Club4/HAF (Holiday and Food) activity programme will create 6 further apprenticeships to enhance the disability physical activity workforce. 10,340 places were funded during Christmas holidays in Surrey.
- Eat Well Start Well(EWSW): 400 early years settings have been contacted and are being assessed. SCC Public Health working with caterers Twelve15 to review menus so that they comply with EWSW award.

Substance misuse is low

- Surrey Combating Drugs Partnership (CDP) launched as a new multi-agency forum, accountable for delivery of the national drugs strategy. This will include co-ordinated action across a range of partners including; enforcement, treatment, recovery and prevention. The three strategic objectives are: Breaking drug supply, treatment and recovery and reducing the generational demand for drugs.
- The Surrey Tobacco Control Alliance was updated at the end of 2022 and the new group will review the first draft of the Surrey Tobacco Strategy in March.

The needs of those experiencing multiple disadvantage are met (see right)

Serious conditions and diseases are prevented

- CVD prevention plan outlining the priorities was approved by the Surrey Heartlands Health and Care Professional Executive (HCPE) and CVD Project Board.
- Funding has been secured to pilot community health checks in East Surrey for those who may not have been eligible for NHS health checks. The aim is to identify high risk behaviours earlier and provide support for those who are at risk of CVD and diabetes.
- Outreach blood pressure and atrial fibrillation (AF) checks continue to be delivered in North Guildford PCN, which was identified as having a higher rate of stroke. Blood pressure and AF checks have also been completed within vaccination centres across Surrey.
- Funding has been secured by Surrey Heartlands from Macmillan Cancer Support to recruit a project manager to target health inequalities related to screening, diagnosis, treatment and living with cancer.

People are supported to live independently for as long as possible

- Following the outcome of a workshop that took place in May 2022, falls prevention in care homes training was delivered in February to care homes in Surrey.
- A new strength and balance plan called Fall-Proof will be distributed to older people living in Elmbridge Borough to engage in self-directed strength and balance exercises to maintain functioning and reduce morbidity associated with falls.
- Live Longer Better Pilot with Elmbridge Borough Council is due to launch with several physical activity awareness training sessions for staff and volunteers within the borough. Developed specifically for people who support older adults, it will cover the benefits of remaining active as people age, tips to encourage people to be more active and suggest different ways to incorporate movement into people's daily routines.
- A new carers dashboard has been developed using data from ASC, NHS and VSCE organisations.
- Children & Young People's social prescribing steering group has been set up to share learning and provide support to establish this role within the system, building on the successful introduction of two CYP social prescribers in East Surrey.
- Following the thriving communities of practice for wellbeing roles currently running in Northwest Surrey and Surrey Downs, work is underway to establish these in the two other places. These groups will support non-clinical wellbeing professionals by providing networking, shared learning, and peer support opportunities.

IN THE SPOTLIGHT: BRIDGE THE GAP OUTR[illegible] SERVICE – A TRAUMA INFORMED 'PLACE AND NEIGHBORHOOD' BASED MODEL OF SUPPORT

Bridge the Gap Alliance is a partnership of third-sector providers within Surrey communities providing a specialist trauma informed model of outreach for adults with multiple disadvantage. Multiple Disadvantage is a term to describe a cohort of people who are experiencing multiple issues including substance use, mental and physical health, domestic abuse, homelessness and criminal justice involvement. This cohort invariably find it difficult to engage with traditional services. This population are often known to many but helped by few, frequently impacting A&E and blue light services.

An independent evaluation of the programme between September 2020 and March 2022 was recently completed. The majority sample were aged 30-59 - potentially, because individuals tend to 'accumulate' additional types of disadvantage over the life course.

The evaluation highlighted the following:

- Improved outcomes for 70% of female participants and 100% of male participants
- All service users, except one, reported having experienced trauma or an adverse childhood event
- Whilst the Mental Health Foundation estimates 1/20 people have a personality disorder in the UK, 36% of the cohort indicated that they had a personality disorder
- Three service users stated that pre programme support, they were in contact with 86 different agencies across the system - only 5% overlapped, highlighting the complexity and the need to provide more joined up support.

The following outcomes and themes were provided by service users:

- All experienced reduced drug and alcohol use as a result of the programme
- Success of Bridge the Gap workers as 'navigators and 'motivators'
- Importance of support being embedded in the community was a critical success factor to enable service users to gain life skills and address gaps in their life experience

The Bridge the Gap programme in Surrey is primarily funded by the Changing Futures programme, which is a joint initiative with the Department of Levelling up, Housing and Communities and The National Lottery Community Fund. Prior to The Bridge the Gap outreach programme, the approximate cost/annum to the wider Surrey system to support one person with multiple disadvantages was £42,500. The evidence shows that Bridge the Gap is a prevention programme that helps to reduce health inequalities for vulnerable populations and save money by improving the individual outcomes. Investing £1.2m/year to maintain services for 60 clients has the potential to save the system £1.35m/year.

The funding for this transformational work in Surrey is due to end in March 2024. Sources of longer-term core funding and short-term innovative funding options are being sought. For example, Changing Futures secured £150,000 funding from NHSE to support those with co-occurring conditions in East Surrey. The programme will include the use of an outreach team including a psychologist to support rough sleepers to find improved ways to access mental health services. The Bridge the Gap Alliance's programme is still however seeking support.

For more information, contact collette.levangilroy@surreycc.gov.uk or lisa.byrne1@surreycc.gov.uk

Health and Wellbeing Strategy: Priority 2 – Supporting Mental Health and Emotional Wellbeing

IMPACT SUMMARY	WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?	HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?	DATA, INSIGHTS AND CHALLENGES – CITIZEN AMBASSADOR RESEARCH - CANCER PERSONALISED CARE/HEALTHY LIVING FOR THOSE WITH LEARNING DISABILITIES (IN PARTNERSHIP WITH SURREY CHOICES)
Improved mental health through prevention of mental ill-health and the promotion of emotional well-being **OUTCOMES By 2030:** • Adults, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources • The emotional well-being of parents and caregivers, babies and children is supported • Isolation is prevented and those that feel isolated are supported • Environments and communities in which people live, work and learn build good mental health **WHO IS LEADING THIS?** **Priority sponsors:** Professor Helen Rostill, Deputy Chief Executive and Director of Therapies, Surrey and Borders Partnership Kate Barker - Joint Strategic Commissioning Convener Liz Williams - Joint Strategic Commissioning Convener **Programme Manager:** Jason Lever, Policy and Programme Manager, Surrey County Council For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: *By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.* In light of the Community Vision and the vital role, communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey's priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support. It also outlines how we need to collaborate so we can drive these improvements, with communities leading the way. Priority Two of the Health and Wellbeing Strategy focuses on enabling our citizens to lead emotionally healthier lives. This priority area is focused on prevention, removing barriers, and supporting people to become proactive in improving their emotional health and wellbeing. Priority Two aims to impact in the following ways: • Ensuring the right early help and resources are available to support mental health across life stages • Support during pregnancy and for young families • Recognising and addressing the impact of isolation • Building good mental health in the range of spaces and places including schools/workplaces.	**The Mental Health: Prevention Oversight and Delivery Board (MHPODB)** took its Work Plan Framework to the Mental Health System Delivery Board on 19 January. A Work Plan Progress Reporting grid is now a standing item at six-weekly MHPODB meetings, to prioritise, support and oversee deliverables across four work areas. This is focused on prioritising programmes and projects delivering on the HWBS Priority Two outcomes which will be covered in a report to this Board in June 2023. The focus is on analysing the evidence base demonstrating need (e.g., new JSNA chapters) and public mental health evidence of effective preventative interventions. This will be combined with an enhanced understanding of the coverage and impact of projects and programmes in place that are delivering against the four outcomes of Priority 2, and so identifying gaps/future priorities. **Surrey All Age Mental Health Improvement Fund (MHIF):** Close working between the MHPODB and MHIF is now established, with MHPODB board members advising on the targeting of specific areas of need and on relevant local or national best practice on which the MHIF should be drawing. There is also a future role for MHPODB to provide guidance and challenge around reporting, mobilisation, implementation and likely impact of performance of successful awards.	Surrey Heartlands Health and Care Partnership commissions Healthwatch Surrey to deliver the Citizen Ambassador Programme, as part of its commitment to ensuring Surrey residents' experiences and views are heard widely. Citizen Ambassadors are everyday people who act as 'peer researchers'. They are given training to deliver small-scale projects and engagements, to hear the experiences of people in the community. **Cancer Personalised Care:** The aim of the research was to understand the lived experience and to investigate what Personalised Care/Support they have found beneficial/ missing in stages of the cancer pathway. Many interviewees found that ***'No attention was paid to my emotional wellbeing'*** **Recommendations:** Clinical teams are need to - Ensure every patient has a holistic needs assessment and Personalised Care and Support Plan, that is shared. - Ensure that all patients have access to a Clinical Nurse Specialist (CNS) or other key worker who can coordinate care, respond to concerns, and support. **People with Learning Disabilities (LD) and healthy lifestyles.** The aim of the research was to investigate healthy living with people with LD to reduce health inequalities **Recommendations:** Health and Well-being Support programmes need to empower clients and -Factor in needs and challenges faced by people with LD -Inform people of primary care benefits (including availability of appointment advocates/health checks. -**Include social activities in healthy living definition** - Encourage home cooking /making healthy food choices - Support online shopping – this may need Investment in training and infrastructure in digital technologies. - Consider socio- economic circumstances - living circumstances, affordability and access - Investigate viable alternatives if an existing activity stops

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 2 OUTCOMES?	IN THE SPOTLIGHT – 'YOUR LIFE BEYOUND CARE'
Adults, children, young people at risk of /with depression, anxiety/other mental health issues access the right early help/resources - A Men's Emotional and Mental Wellbeing project officer was recruited into the SCC Communities and Prevention team in January. - A full mapping exercise has started of existing mental health and wellbeing support for men. In addition, Mentell has recruited a 3 day a week men's mental health champion for Surrey. - In SABP, a suicide bereavement workshop was delivered to 20 professionals working with young people in Surrey, and a new staff suicide prevention training model is being planned - The Independent Mental Health Network (IMHN) is undertaking an insight survey called 'Pathways to Change' looking into the experiences of South Asian adults. - Surrey Coalition of Disabled People's research project, 'Compassion in Crisis' is looking at adults with autism and learning disabilities who have experienced mental health crisis. - Surrey Dementia Road Map, Dementia Connect (Alzheimer's Society), Healthy Surrey and Surrey County Council websites have published local resources to ensure people have access to the range of Surrey support groups available. - Frimley Health & Care ICS carried out a targeted mental health and wellbeing comms campaign, focused on Talking Therapy services and community wellbeing offers; around 3000 people clicked on advertising and early website analytics suggest successful flow through to their service websites. **The emotional well-being of parents and caregivers, babies and children is supported** - AFloaT is a new SABP service taking professional referrals in the Surrey Heartlands area to support those affected by moderate to severe mental health difficulties as a result of maternity experiences. It is working closely with maternity services at the 4 acute hospitals and within the wider system Perinatal Mental Health pathway. - The Breastfeeding Strategy has been refreshed and updated over the past 6 months, in recognition of its importance as a key public health priority to optimise health outcomes for mothers/ birthing parents, babies and their families. An action plan is near completion, after extensive professional and wider stakeholder feedback, and will contain key overarching themes for improvement to be initiated in 2023, with further implementation over the next five years. - The Children & Young People's Emotional Wellbeing and Mental Health Strategy was published in February 2023, action plan to follow. - The My Safety Plan project pilot at Royal Surrey and Epsom General Hospital has sought to improve communication between acute settings and schools, with a full roll out due in the Summer Term. **Isolation is prevented and those that feel isolated are supported** - End Stigma Surrey has published its toolkit on how to reduce stigma, a directory for how to challenge discrimination and blogs of Lived Experience Champions' stories. - In the Hope Community Project, a total of 232 people attended the range of themed activities during 2022 at Richmond Fellowship, and 40 clients have been attending mosaic making classes at Mary Frances Trust. - £22,000 has been secured by SCC to support Creative Response to offer art therapy to people with mental health conditions. **Environments and communities in which people live, work and learn build good mental health** - A Prevention (Mental Health) working group for key neighbourhoods in Reigate and Banstead (incorporating ICB, SCC and R&B Community leads) has been set up to understand the key issues for residents and current provision. - Action learning sets have been established for Mental Health First Aiders. Over 100 people have so far been trained in 2023. - The Green Social Prescribing initiative has funded RSPB Farnham Heath to install a webcam at a nature reserve bird feeder, with the first Surrey care home in Epsom receiving technology training to enable residents to view this live feed. - Plans are finalised for a therapeutic green space at the SABP CAMHS site in Epsom, to add the benefits of nature connectedness to patients' treatment plans. The garden secured £25,000 in grant funding and will be built in partnership with Volunteer in Yourself who will use the opportunity to train young people with mental health issues.	Surrey Children's Services has worked with Coram Voice to gain feedback from **looked after children and care leavers** on their lives and experiences in care, and what is important to them. Positive experiences included feeling safe, feeling that they knew and trusted their social workers and personal advisors, reporting to be 'more happy' with their appearance than the non-looked after population and the youngest and oldest children really knowing their life stories. Among the areas for improvement were that looked after children would like to see their family more. Not all children stated that they had at least 'one really good friend' and they felt stigmas associated with being in care. Life satisfaction for care leavers was lower than for the general population, with barriers of money, location and their mental health. They also find it more difficult to cope financially than their peers. Some practical suggestions came out from webinar discussions with practitioners and policymakers in January. These included doing more to support friends, which could improve attendance at drop in and user voice sessions for care leavers. A system challenge was highlighted that for some children placed out of area will be placed on the housing register in Surrey when they turn 18. Consideration should be given to them being placed on a register in the area they are living, to enable them to stay in contact with their friends. An action plan is in development. For more information, please contact elaine.andrews@surreycc.gov.uk.

Health and Wellbeing Strategy: Priority 3 – Supporting People to Reach their Potential

 **IMPACT SUMMARY People reach their potential**	**WHAT WILL BE DIFFERENT FOR PEOPLE IN SURREY?**	**HOW HAS COLLABORATIVE WORKING BETWEEN HWB BOARD ORGANISATIONS ADDED VALUE AND CONTRIBUTED TO THE ACHIEVEMENT OF THE OUTCOMES?**	**DATA, INSIGHTS AND CHALLENGES - COST OF LIVING AND PEOPLE WITH DISABILITIES**
OUTCOMES By 2030: • People's basic needs are met (food security, poverty, housing strategy etc) • Children, young people and adults are empowered in their communities • People access training and employment opportunities within a sustainable economy • People are safe and feel safe (community safety incl. domestic abuse; safeguarding) • The benefits of healthy environments for people are valued and maximised (incl. through transport/land use planning) **WHO IS LEADING THIS?** **Priority sponsor:** Mari Roberts-Wood, Managing Director, Reigate and Banstead Borough Council **Programme Manager:** Olusegun Awolaran, Policy and Programme Manager, Surrey County Council For more information on the performance of individual programmes and projects within this priority such as progress against key milestones please contact the relevant programme manager via healthandwellbeing@surreycc.gov.uk	The Community Vision for Surrey describes what residents and partners think Surrey should look like by 2030: By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind. In light of the Community Vision and the vital role communities and staff/organisations in the health and care system play in its delivery, the Strategy sets out Surrey's priorities for improving health and wellbeing across the priority populations for the next 10 years. It identifies specific groups of people who experience poorer health outcomes and who may therefore need more support and outlines how we need to collaborate so we can drive these improvements, with communities leading the way. Priority 3 of the Health and Wellbeing Strategy focuses on enabling our citizens to lead healthier lives. This priority area is focused on primary prevention and addressing the wider determinants of health. Priority 3 cuts across five outcomes and action focuses around: • Ensuring that everybody has enough income to live on and lives in good and appropriate housing • Building social capital in communities • Improving access to training and jobs • Preventing crime and supporting the victims of crime including domestic abuse -supporting and empowering survivors • Improving environmental factors that have an impact on people's health and well-being.	The HWB Board has and will be consulted on local Integrated Care Strategies. On Wednesday 1st February 2023, the **Surrey Heartlands Integrated Care Strategy** alongside the Joint Forward plan was officially launched at its ICS Expo. (Joining up care across Surrey Heartlands - YouTube). The Strategy consists of three system ambitions that have been developed based on the priorities and ambitions of their strategic context. The ambitions are: 1. **Prevention**: Reflects the three priorities within Surrey's Health and Wellbeing Strategy. 2. **How we will deliver care differently**: Based on feedback from Surrey residents, the ICS will deliver care by making it easier for people to access the care they need, when they need it and by creating the space and time for the workforce to provide continuity of care. 3. **What need to be in place to deliver on these ambitions:** To help in the delivery of the first two ambitions, the ICS will seek to work: With communities and enable them to lead locally driven change; with digital services and how data is used; with developing a workforce with the right culture, values, behaviour, skills, training and leadership to face the demands of the future. **Frimley Health and Care** have developed a draft **Integrated Care Strategy – Creating Healthier Communities,** due to be approved by the IC Partnership in March 2023. It has two overarching themes – reducing health inequalities and increasing healthy life expectancy and focuses on the following Strategic Ambitions: Starting Well; Living Well; People, Places and Communities; Our People; Leadership and Cultures; Outstanding use of Resources.	Surrey Coalition of Disabled People members have been surveyed; 45% of their members had gone without food, 76% had not turned their heating on, while 43% no longer were able to meet the additional costs associated with their disability and have felt the financial impact of increased bills, food, transport and care costs. ***"I use a CPAP machine, and this is plugged in constantly. I cannot find any information on how much the cost of electric is for this. I have a heated blanket for my bed. I know this is not cheap to run but I have no choice, if I get too cold my joints seize up, including my back. I cannot afford to put fuel in the car and my disability makes it hard to get to a bus stop"*** ***"Although I have changed my diet and eat foods that are cheaper to heat, I have not drunk hot drinks at home this year due to cost of boiling kettle."*** ***"I never asked to borrow money, I have my pride, but a Parish Priest in Woking gave me £50. It was an embarrassment, but I took it. Later I cried in my car. Even with my car, I only drive for groceries or medical/health related reason - scared to go out if I won't be back by 3pm because I'll lose the closest parking space... I can't see a way out of this and my life isn't worth living anymore".*** They, however, require help in accessing information and signposting, getting direct funding, getting technical support, devices, training and education. Other issues that need to be addressed include ensuring that all warm hubs and community fridges/ food banks are accessible and publicise their locations as widely as possible; deliveries from foodbanks to those unable to leave their homes should also be considered. For more details contact Nikki Roberts, Nikki.Roberts@surreycoalition.org.uk

WHAT HAS BEEN ACHIEVED THIS QUARTER UNDER REFRESHED PRIORITY 3 OUTCOMES?

People's basic needs are met

Since the launch of the Warm Hubs across Surrey, a total of 103 hubs have been in operation, excluding libraries. Reports received from 62 of the hubs show that a total of 5,090 persons visited in December alone. General enquiries can be directed to: warmhubs@surreycc.gov.uk

- The Surrey Energy Advice Tool is now live. The online tool can help any Surrey resident with their energy use. It requires residents to answer a short series of questions and the tool will provide information tailored to specific circumstances of the resident. Based on the answers, the respondent will receive information on grants, support and advice and non-financial help on a range of topics including finding free or part-funded schemes to make your home more energy efficient; signpost to debt relief grants; where to find additional services such as clothes and food banks; and fuel vouchers.

Children, young people and adults are empowered in their community

- A pilot 'Discover Asset-Based Community Development' training course (90mins x 8 online) has been designed by Nurture Development (ND)for SCC. If successful there will be a roll-out of this course for system partners. It will complement existing ND and Health Creation Alliance learning opportunities in Surrey.

People access training and employment opportunities within a sustainable economy.

- SCC held a National Apprenticeship Week 2023 event, where apprentices attended a workshop session about shaping the future of SCC's Apprenticeship Programme and designed a recruitment campaign to attract apprentices to SCC.
- No One Left Behind Skills and Employment Network's in-depth interviews have been completed with those most excluded from employment. The final report, including focus group results, is expected in March.

People are safe and feel safe

- The Domestic Abuse Act 2021 (Part 4) placed a statutory duty on SCC to provide support in safe accommodation for everyone. SCC's safe accommodation needs assessment identified gaps in refuge provision in Surrey for adult males, LGBTQ+ and Gypsy, Roma & Traveller communities. 'I Choose Freedom' were therefore granted funding from SCC to set up a two-year pilot project to provide eight self-contained dispersed accommodation units for single people across Surrey. I Choose Freedom and SCC have so far acquired six dispersed, self-contained properties and are hoping to secure a further two asap. The spaces will be advertised with the National Domestic Abuse Helpline (0808 2000 247) and on the Mankind Portal (01823 334244). Refuge Accommodation for All (RAFA) Project is now live and is providing single spaces for anyone that has barriers to shared living. You can find out more about the RAFA project by contacting Louise Gibbins at louise.gibbins@surreycc.gov.uk
- Following the update to the Health and Wellbeing Board in November the Serious Violence Duty was ratified on the 31st of January 2023. To begin to meet the requirements of the duty an Operational Group has been established with representation from all the specified authorities and work had begun to gather relevant information and start to define what serious violence is in Surrey. The OPCC has taken on a convening role and is working to support the delivery of the Duty. For more information, please contact Sarah Haywood at sarah.haywood@surrey.police.uk
- There will be a Community Safety Assembly 17th April 10am-12pm, Quadrant Court, Woking. HWB Board members should contact Sarah Haywood at OPCC (as above) if you would like to attend.

The benefits of healthy environments for people are valued and maximised

- SCC has been awarded a small grant from UK Research and Innovation & The Young Foundation to support Surrey Minority Ethnic Forum's (SMEF) Muslim Women and Girls' Eco-Warriors group to become embedded researchers in their own communities to understand approaches to climate change and green health and wellbeing in minority ethnic communities. The Phase 1 funding for this project will run February- August 2023, with an opportunity to apply for phase 2 funding later in the year. For more information, please contact Jane Soothill at jane.soothill@surreycc.gov.uk
- SCC has developed Countywide Liveable Neighbourhood zones around urban areas (key towns). There was also a bid for funding the development of a selection of zones to Active Travel England in February 2023. For more information, please contact Lyndon Mendes at lyndon.mendes@surreycc.gov.uk

IN THE SPOTLIGHT – DEVELOPING ANCHOR INSTITUTIONS TO IMPROVE WORKFORCE CAPACITY

Frimley Health and Care has received just under £100,000 from Health Education England to develop a programme to understand its communities better so that it can target what needs to change to make health and care roles more attractive and accessible to local people. The programme sits under the auspices of HWB Strategy's outcome 'People access training and employment opportunities within a sustainable economy' and supports the Strategy's Workforce Recovery and Development system capability. It will potentially focus on a specified priority population, and as such, to date the programme has been gathering examining best practice from other areas and collecting data about the community, drawing on data for Surrey Heath. It will draw key stakeholders together, including SCC Economy and Growth/Public Health teams and Department of Work and Pensions, at a workshop to develop a logic model for the programme in March.

The focus of the programme is:

- **Access to work**; what processes/criteria do we need to change to enable more people to access good work
- **Improving retention/health and wellbeing**; by understanding our workforce; targeting those staff living within areas of deprivation within our communities
- **Exploiting opportunities to increase workforce capacity**; using data to identify where we best focus e.g; those for whom English isn't their first language, men over 50 who need a second career which is less labour intensive, people with mild autism/learning disabilities who need an alternative/more supported route into work

The intention is to share best practice and create momentum regarding the benefits of working with anchor institutions. There is also a commitment to sharing progress with other health and care systems, particularly those within the NHS South East area.

For more information, contact Sandra Grant at sandra.grant19@nhs.net

Joint Strategic Needs Assessment: Progress as of February 2023

For further information please contact the PH Intelligence Team phintelligence@surreycc.gov.uk

Chapter published in last Quarter: 1

	Chapters published
Priority populations	***Children and young people with additional needs and disabilities*** We have now published our JSNA chapter focusing on children and young people with additional needs and disabilities aged 0-25 years in Surrey. This JSNA centres the voice of children, young people, and their families at the heart of the insight and experience gathering process. It should be read alongside the Surrey Additional Needs and Disability Partnership self-evaluation and the Children and Young People with Additional Needs & Disabilities: 2022 -2030 Sufficiency Plan (both summarised in the chapter). A further JSNA chapter on learning disabilities across all ages will be published imminently.

Planned JSNA chapters to be published by June 2023 / development started

	Chapter to be published
Priority 1	***Screening services* –** Publication scheduled for April 2023 ***Substance use* –** Publication of full chapter scheduled for April 2023. Visualisations of data surrounding substance use of adults and young people in Surrey were updated and published in 2022. ***Multiple disadvantage* –** Development started
Priority 2	***Mental health of adults* –** To be published March 2023 ***Mental Health of children & young people* –** Development started
Priority 3	***Economy* –** Development started ***Housing* –** Development started
Priority Populations	***People with learning disabilities* –** To be published March 2023 ***People experiencing domestic abuse* –** Development to start Summer/Autumn 2023
Other	Responding to recent international developments, the JSNA has added a 'rapid needs assessment' to those completed during the pandemic, exploring ***Migrant Health***. This will be delivered in several phases with the focus of phase one being on asylum seekers and refugees which will reference the Afghan and Ukrainian support schemes that are currently in place. Phase one of the needs assessment is currently at draft report stage. Due to the sensitive and dynamic nature of this area of healthcare we are working through what can be shared publicly via the JSNA website. To discuss in more detail please contact Qanita Vora, Public Health Programme Lead, via qanita.vora@surreycc.gov.uk.

NOTE: Latest Census 2021 analysis can be found here on Surrey-i

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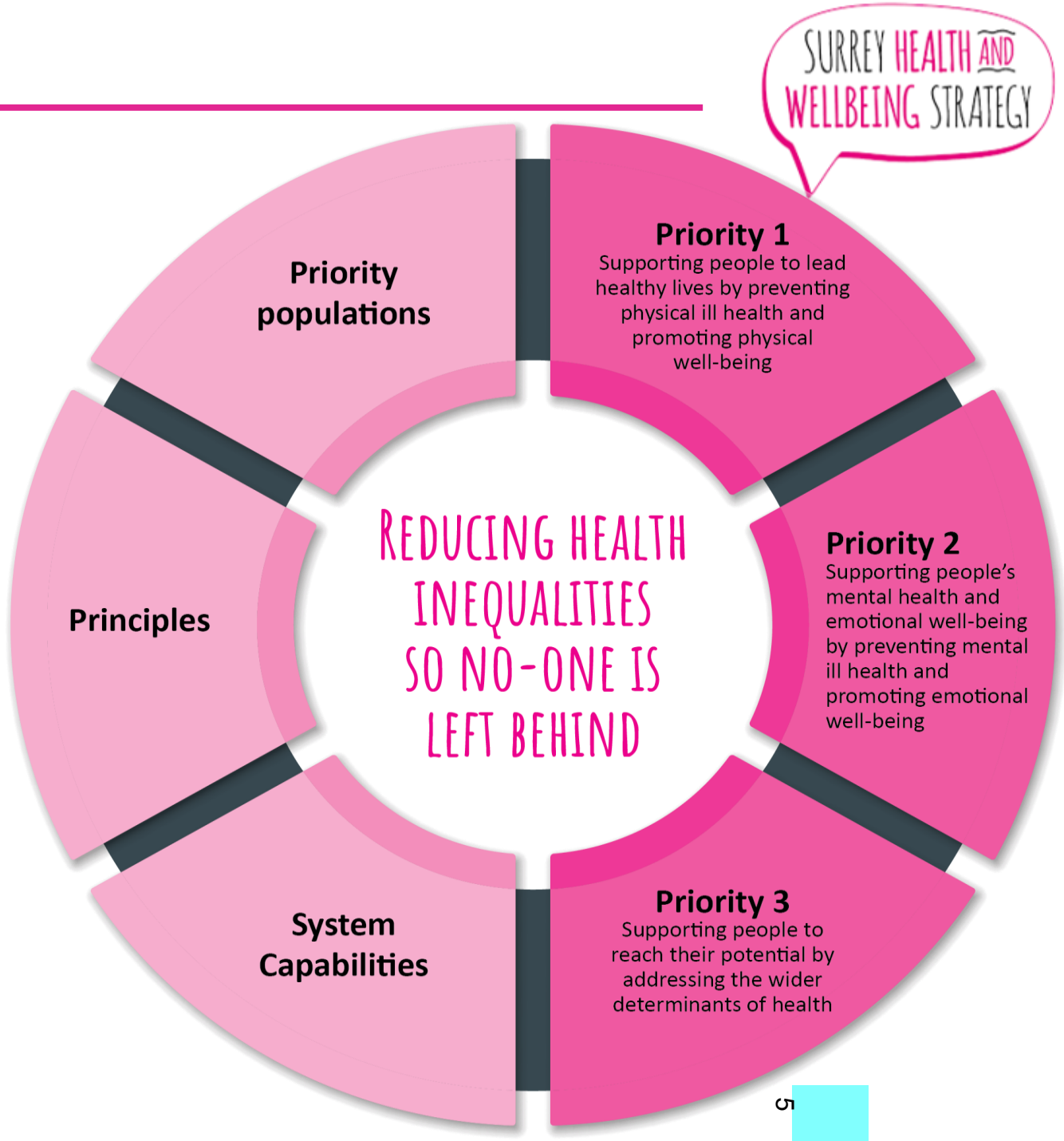
Communications Update

Communication Activity supporting the
3 priorities of the health and wellbeing strategy



Priority 1

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

Sexual Health

Through awareness days, helping people access sexual health services and reducing stigma

World Aids Day & PREP Awareness Week

- Social Media
- Internal Comms
- Pop up stand at Woodhatch to raise awareness

Group A Strep/iGAS

Supporting Schools and Communities following confirmed iGAS cases

- Media Handling – working with UKHSA
- Social Media
- Internal Comms

COVID-19/FLU

Raising awareness of vaccines to increase uptake

- Social Media
- Partner Comms
- Internal Comms

Priority 1

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

Getting the right help

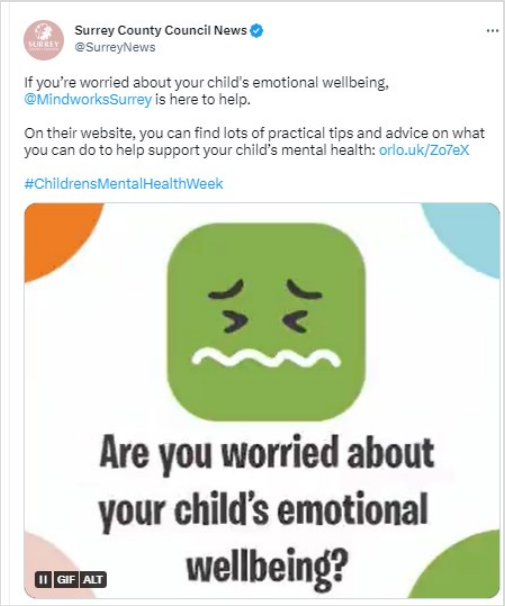
- Printed and online resources including leaflets
- Activity sheets being provided to schools

Leading work to support Surrey parents of children, aged from 0-5 years old, to help them access the right NHS support if their child is unwell, as part of our wider joint winter communications plan. The resources aim to help parents navigate the local health system more easily and provides bite sized explanations of the help they can expect from pharmacies, NHS 111, Surrey 0-19 advice line, Call a Midwife and other NHS services.

This campaign was developed at a time when we have seen a rise in attendances at A&Es and increasing pressures on the health system.

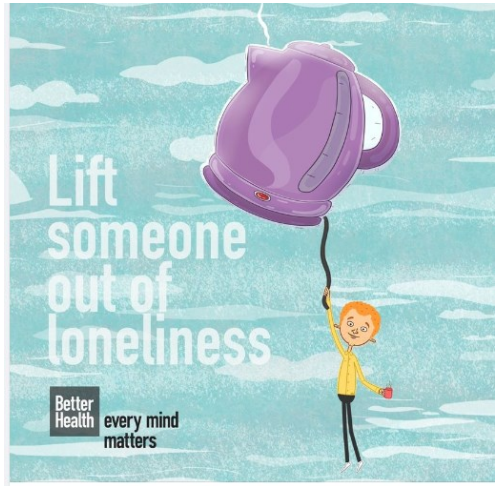
Priority 2

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



Children's mental health week
Helping parents to support their children and access mental health support through Mindworks

- Messaging to parents through schools
- Social Media
- Internal Comms – Staff as parents/grandparents

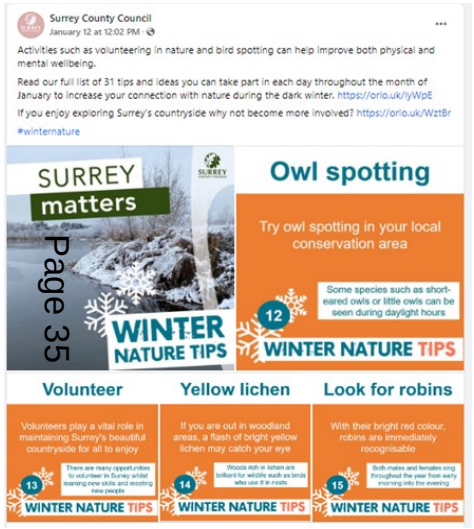


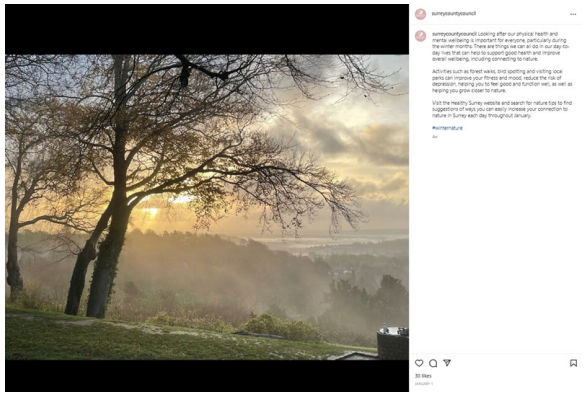
Building mental health resilience
Using marketing campaigns to highlight mental wellbeing strategies to build resilience

- Social Media
- Editorial – Surrey Matters
- Internal Comms – Staff wellbeing networks

Priority 2

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





Winter nature campaign

Thirty-one tips for connecting with nature – one for each day in January – were hosted on Healthy Surrey to encourage people to get outside during the winter.

- More than 73,000 impressions on social media (number of times displayed on residents' devices), particularly strong Instagram engagement
- Nearly 300 link clicks

Dementia prevention

Magazine-style editorial highlighted ways to keep your brain healthy and reduce dementia risk

- Links to local support services
- One of the most-clicked articles in Surrey Matters, opened 9,000 times
- Wider campaign being developed linked to joint dementia strategy

Priority 3

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

- **Domestic Abuse** campaign highlighting coercive and controlling behaviour
- Campaign creative developed with people with lived experience of abuse
- Targeted at lesser reported groups including LGBTQ+, older people and ethnic minority groups.
- Outdoor media in **35 locations** across Surrey at rail stations and bus stops. Included a QR code linking directly to support.
- **3 SFRS fire engines** with vinyl wraps showing the DA message
- Posters created to reach digitally excluded
- Videos promoted through social media focusing on key areas of control Isolation, Monitoring and Financial
- Campaign promoted by partners in the Surrey Against Domestic Abuse Alliance.

Priority 3

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

- Changing Futures - supporting people with multiple disadvantage - substance use, mental illness, domestic abuse, homelessness and contact with the criminal justice system.
- 'Michael's story', a video which highlights the impact that the Changing Futures Bridge the Gap partnership can make to people with multiple disadvantage.
- Released on Christmas Eve to highlight the plight of the homeless at Christmas.
- Through Facebook the video was seen nearly 17k times, with 3833 clicks.

Michael's Story - Video
https://youtu.be/jkHfGKAwSrM

Launching the Surrey Heartlands Integrated Care Strategy

Activity to support the launch of our system-wide ICS strategy

- The Integrated Care Strategy was launched at a Surrey Heartlands Expo event on 1 February, attended by over 300 people
- The event was an opportunity to share the ICS' plans and priorities, showcase the work happening across Surrey to support integration and encourage networking between partners.
- The strategy, which sets out the ambitions and priorities for Surrey, has been published online in full and summary formats
- The strategy is also summarised in a video, already viewed more than 300 times

SURREY HEARTLANDS EXPO

SURREY HEALTH AND WELLBEING STRATEGY

DELIVERING THE COMMUNITY VISION FOR SURREY

Frimley Health and Care

NHS Frimley

Update on Frimley Health and Care Integrated Care System Strategy 'Creating Healthier Communities'

Surrey Health and Wellbeing Board
March 2023

Frimley Health and Care

NHS Frimley

Executive Summary:

- The Health and Care Act (2022) established a number of new operating models in law, including the establishment of Integrated Care Partnerships (ICPs). The Frimley ICP, one component of the broader Frimley Integrated Care System (ICS), held its first Assembly meetings in September and November 2022, both of which were well attended by a wide and diverse range of partners from across our health and care system.

- The statutory remit of ICPs is relatively brief, with significant local discretion to use these Joint Committees in a way which helps ICSs best meet their locally defined strategic objectives. One of the requirements however is that ICPs act as the final approver of the ICS Strategy, which should set out a system's strategic objectives and priorities over a future multi-year period.

- National guidance published in the Summer of 2022 mandated all of the new ICPs to produce an "interim" strategy by 31 December of the same year, noting that some systems were starting from different points. The Frimley ICS as a relatively mature system partnership already had a strategy, *Creating Healthier Communities*, which was produced in the Autumn of 2019. There was broad acceptance by the ICP Assembly that the world had changed significantly since 2019 and that refreshing the strategy in line with national guidance and the health and care landscape would be a productive exercise in testing new priorities within the existing strategy delivery framework.

Frimley Health and Care

NHS Frimley

Draft Frimley ICS Strategy:

- The purpose of the strategy is to set the overarching vision and intent for the health and care system over the next five years, focusing in on our shared strategic objectives as a partnership. This strategy will not contain all of the answers about how organisations and partners will make this happen, but does set out a number of key priorities within each of the six strategic ambitions which are:
    - Starting Well
    - Living Well
    - People, Places and Communities
    - Leadership and Cultures
    - Outstanding use of Resources
- Following the Frimley ICP Assembly held in November 2022, a team from across the Frimley ICS has been working on the production of this strategy refresh which is presented to the Health and Wellbeing Board for discussion and feedback. It is intended that the Strategy will go back to the Frimley ICP Assembly for final endorsement in March 2023, following a round of engagement with Boards and Committees from across the Health and Care partnership. The Health and Wellbeing Board is asked to provide feedback on the draft in its current form. The Health and Wellbeing Board is not being asked to approve the strategy, given this authority is reserved in law for the ICP, although its support and endorsement is sought as a part of its ongoing development and approach
- The Health and Wellbeing Board is asked to discuss and share feedback on the draft multi-year ICS Strategy and to support the strategy ahead of the March 2023 Frimley ICP being asked endorse the strategy – in line with the roadmap as set out in the next slide.

Frimley Health and Care

Join the conversation

Timescales

Engagement Output Generation	22nd November: ICP Workshop takes place	25th November: Review contributions from those unable to attend ICP	
Refresh Strategy Content	By 8th December: Strategy refresh is drafted	9th December: Circulate for ICP review	15th December: Follow on amendments made and shared
Finalise and submit Draft Interim Strategy	20th December: Final deadline for comments	23rd December: Submit to DHSC/ NHS England	
Next Steps	December-March Further engagement on interim Strategy	March 2023 ICP sign off of final interim strategy	

Boards and Committees across the Partnership will have an opportunity to formally review and comment during Q4 2022/23. Final approval of the strategy is a responsibility reserved for the ICP which will want to assure itself that broad engagement has been undertaken. Patient and Public views will be sought through a number of channels, including the engagement portal.

Frimley Health and Care

Creating healthier communities with everyone

DRAFT (V2) Creating Healthier Communities Strategy Refresh 2022

Frimley Health and Care Integrated Care System

Bracknell Forest ⬡ North East Hampshire and Farnham ⬡ Royal Borough of Windsor and Maidenhead ⬡ Slough ⬡ Surrey Heath

Contents

Creating healthier communities with everyone

Using this document

This document is interactive. Throughout the strategy there are a number of links to external websites, resources, videos and further information which you can access if reading on a digital device.

Wherever you see this symbol, you will find an interactive link that will provide further context and information.

You can also use the contents page to navigate around the strategy. If you are reading a printed copy and wish to access any of the digital content, please **contact** the Frimley ICS team to find out how.

Foreword

After a century of rising living standards, life expectancy and real incomes, our population is now facing a set of challenges which have not been experienced for many decades. For many of our residents, however, the COVID-19 pandemic which hit at the start of this decade, painfully exposed some of the inequalities which have been present for generations. The last three years have highlighted some of the main inequities which are major contributors to deprivation, variation in health outcomes and lived experience as residents of our geography.

In the months leading up to the unforeseeable onset of the pandemic, public sector leads in the Frimley Health and Care ICS geography had started the process of identifying these disparities and putting plans in place to address them. The Frimley ICS Strategy, *Creating Healthier Communities*, which was published in the Autumn of 2019, recognised these challenges and partners agreed on two core objectives; firstly to **reduce health inequalities** and secondly to **increase healthy life expectancy**.

The onset of the global pandemic significantly underlined the importance of these areas of focus. Never before in the modern day, had the lives and liberties of our residents been so restricted, and subsequently disadvantaged, in such a short period of time. Almost three years later, even with COVID-19 causing less of a daily impact, this offers little in the way of comfort to our residents; the economic shock resulting from this period and the subsequent cost of living crisis indicates an extremely difficult period ahead for all of us.

This context demonstrates the importance of this refreshed strategy, which sets out our collective ambitions as a partnership over the years ahead. Readers will note that the mission remains largely unchanged from three years ago, but much of the approach will be new, reflecting a fresh urgency and focus on the significant number of people in our population who experience an unacceptable degree of variation in their quality of life and health outcomes.

Undoubtedly, the world will continue to change rapidly over the years ahead and our strategic purpose and intent will need to adapt accordingly. This strategy therefore is a response to the 'here and now' of the challenges in front of us and is likely to evolve. Our aim is to ensure that the new Integrated Care Partnership can capitalise on the dynamic brief with which it has been established and create the collective sense of purpose which will be needed to deliver both the priorities set out in this document and the as yet unknown difficulties which will continue to emerge.

Despite the unprecedented challenges which lie ahead of us, we remain optimistic for the strength of our partnership and the huge impact which can be made for our population by working together. On this basis, as leaders of public sector bodies from the breadth of the Frimley geography, we commend and support this refreshed strategy.

Click here to learn more about the membership of the Integrated Care Board

Executive Summary

Our Objectives

We remain committed to delivering the two overarching objectives which were defined by the 2019 Frimley ICS strategy; *Creating Healthier Communities*. Our partnership focus will continue to be defined by delivering improvements against the following two headline measures:

(1) **Reducing Health Inequalities** for all of our residents who experience unwarranted variation in their **outcomes** or **experience**

(2) Increasing **Healthy Life Expectancy** for our whole population, ensuring an improvement not just in length of life but in the quality of those years as well.

Our Strategic Ambitions

The Strategic Ambitions which were established in 2019 are retained with new areas of focus and energy against a refreshed set of priorities which better reflect the challenges of 2023 and beyond.

- **Starting Well**
- **Living Well**
- **People, Places & Communities**
- **Our People**
- **Leadership and Cultures**
- **Outstanding Use of Resources**

Each of our Strategic Ambitions will focus on a discrete number of headline priorities in the 3-5 years ahead, which are likely to be some of the most challenging that the health and care system has ever faced. You can read more about these, and the other areas of work for each ambition, in the dedicated sections of this strategy document between pages 13 and 35.

Our Headline Commitments in this Strategy

Starting Well
- Addressing health inequalities through a focused approach to meeting the needs of vulnerable children who experience deprivation and poverty
- Initiatives to improve the lives of babies and Children in the first 1001 days through to primary school.
- Supporting and strengthening partnerships around health visiting and school nursing, working in partnership between the NHS and Public Health to make improvements in these vital roles.

Living Well
- A renewed focus on cardiovascular disease and its causes which contribute to hundreds of avoidable deaths annually
- Working with partners across Places and Public Health to help our population maintain Healthy Weights
- Helping people in our population to quit smoking by supporting them with advice and alternatives

People, Places & Communities
- A clear approach to engaging with our population at place and system levels
- Ensuring all of our diverse populations are represented with the creation of an ICS inclusivity framework
- Exploring citizen leadership and creating opportunities to develop decision making in our communities

Our People
- Creating a joint workforce model for health and care to give our people fulfilling and varied career opportunities
- Widening access to employment and keeping the people we have by ensuring we provide great places to work
- Strengthening partnership working and new models of care for our staff, residents and their communities

Leadership and Cultures
- Deliver our system equality, diversity and inclusion ambitions
- Use our leadership networks to accelerate the spread and adoption of system change
- Nurturing a shared learning culture to create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities

Outstanding Use of Resources
- Reduce the need for acute and specialist services through investment in preventative and wellbeing interventions
- Utilise digital innovation to deliver greater value for our population
- Make best use of our estates, community assets and anchor institutions by sharing capacity across our partnership

About the Frimley Geography and System Partnership

The organisations involved in planning and providing public services locally, are working together with the community to shape future improvements.

Frimley Health and Care brings together Local Authorities, NHS organisations and the Voluntary Sector together with a clear shared ambition to work in partnership with local people, communities and staff to improve the health and wellbeing of individuals, and to use our collective resources more effectively.

The system has a diverse population of over 800,000 people in a broad geography which spans East Berkshire from Bracknell to Slough, North East Hampshire, Farnham and Surrey Heath.

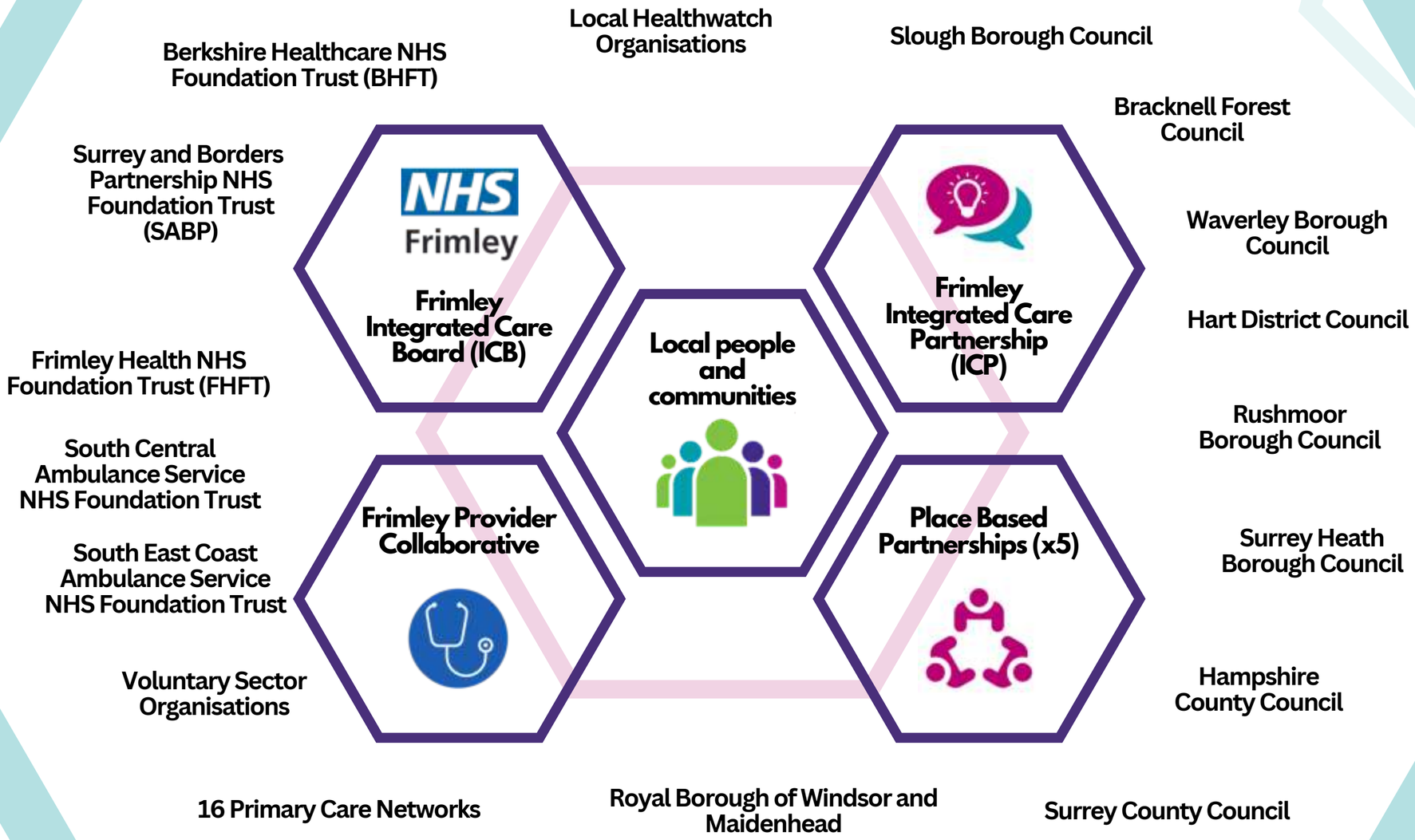
Our partnership, comprised of dozens of Public Sector and VCSE organisations, is led by committed clinical and professional leaders. We have been working together since 2016 when our very first partnership plan was published which set out our aspiration to unlock the benefits of greater partnership working and use our collective resources more effectively to improve the health of our population.

As a result, considerable progress has been made promoting health and wellbeing, improving care and services, and making services more efficient. We have brought people together to integrate services and work across organisational boundaries, regardless of the system and organisational architecture which regularly changes around us.

Given the challenges of the period since the last strategy was produced in 2019, the partnership has come together to create this newly revised and refreshed strategy. This new strategy builds on that work and describes the shared ambitions and priorities which will be delivered, and which will make the most difference to individual people's health and wellbeing.

Frimley Health and Care

Frimley Health and Care Integrated Care System (ICS)



Click here to learn more about our Partners

Creating Healthier Communities – The Frimley ICS Strategy

"Creating Healthier Communities" was published in 2019 as the first Frimley Health and Care ICS Strategy. The strategy was designed following significant co-production between partner organisations, the third sector, our workforce, patients and the public.

The strategy was heavily informed by the data and insight available from the Connected Care platform and led to the formation of six Strategic Ambitions which have comprised the programme architecture for strategy delivery between 2019 and 2022.

Click here to read more about the 'Creating Healthier Communities' strategy published in 2019

Our Integrated Care Partnership (ICP)

The Frimley Integrated Care Partnership, established in July 2022 is a joint committee between upper tier Local Authorities in the Frimley ICS geography and the NHS Frimley Integrated Care Board. At its core is an ICP Assembly, bringing together clinical and professional leaders of public sector, voluntary sector and charitable organisations which have an interest in improving the health and wellbeing of over 800,000 people who reside in the Frimley ICS geography. The ICP provides a platform for a broad range of stakeholders who are committed to making this ambition a reality.

Building on our engagement with our partners, we have established the Frimley ICP to have a strategic role, considering what arrangements work best in our local area by creating a dedicated forum to enhance relationships between leaders across the health and care system.

The agreed remit for the ICP is to:

- Consider and set the strategic intent of the partnership; act as final approver of the ICS Strategy, including the proposed programmes of work, outcomes and intended benefits
- Act as an objective 'guardian' of the ICS vision and values, putting the populations needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus.
- Provide a forum for consideration of wider determinants of health and health inequalities, taking fullest advantage of the opportunities arising to hear the views and perspectives of the broadest range of local stakeholders and democratic representatives.

The assembly will ensure a voice for those who speak on behalf of their communities and bring a very new approach to the design of our strategy. The Assembly met for the first time in September 2022 and again in November 2022, primarily to progress the consideration and production of this refreshed strategy document.

Partnership engagement

On Tuesday 22nd November, the second Frimley ICP Assembly took place at South Hill Park Arts Centre in Bracknell. The event brought together over 50 members of the ICP, representing local Health, Care, Local Authority, Healthwatch and Voluntary Sector organisations from across the Frimley Geography. Through a face to face facilitated workshop, Assembly Members from across the ICS met together to:

- **Understand the journey so far on the development of the ICS strategy**
- **Explore what has changed since the co-production of the strategy in 2019**
- **Enable ICP Assembly members to co-design the key areas of focus for our ICS strategy refresh**

The feedback gathered during this session and from other stakeholders who weren't able to join on the day, has been used to support and shape the development of this strategy refresh.




Collective feedback

- The language, messages and engagement of the strategy need to be translated into something our population wants to embrace. We must **hear the voice of our population** to support co design of solutions
- The strategy must be **inclusive of all partners** to provide transparency and collective opportunity across the system
- Improved understanding of the current landscape and assets is important so we can make connections and **understand multiple partner perspectives**
- Stronger working with the **voluntary sector** is imperative
- The future is uncertain - we must be **open and honest about the reality we face** - both in terms of challenging economic situation and increased demand on services

Raise the aspirations of our children and young people
Hear the children and young person's voice
Support the next generation - quality of life post 16
Greater working synergy with education

Starting Well

What does living well mean to our adults and older population?
This cohort often has the greatest health needs - how do we better engage?
Feels very disease focussed - should this be more about wider determinants?
Dual aim for this ambition - Living healthily and living well

Living Well

We need a VCSE Alliance to support these conversations
Understand the unique aspects of community assets, needs and priorities
Stronger links with Secondary Care to support community needs when discharged
Stronger links with Local Authority and Primary Care Networks (PCNs)

People, Places and Communities

What can we do to support a wider staff network including voluntary sector?
How can we tackle the temporary staffing problem as a system & across system?
How can we consider incentives to live and work in Frimley?
We need a shared narrative across partners

Our People

Values must reflect our 'collective' organisation
Exposure to more people. We need the reach out to learn how we can change culture
How is value demonstrated and who is best placed to express this?
Improved visibility of what's happening across the system?

Leadership and culture

How far can and should we share money and resources?
Co-design of joint investment models
Promotion of economic growth, shared goals and objectives
How do we have an honest conversation with the public?

Outstanding use of resources

Frimley population insights

Population 800,000

Increasing by 6.4% by 2036 - about 47,000 people - with the largest increases in the over 60's and 13-18 age group

Life expectancy 81 84

Healthy life expectancy 66.8 67.4

Healthy life expectancy at birth

People that live in recognised areas of deprivation will often have poorer outcomes and on average will have a lower healthy life expectancy. Most of our population don't live in areas of deprivation. All areas contain pockets of deprivation, but they can be less visible due to nearby affluence. In Slough there are many more people living in deprivation.

Over 30% of the population are in the 10% least deprived in society

Around 3% of the population live in the most deprived areas of England

About the population across our 5 places

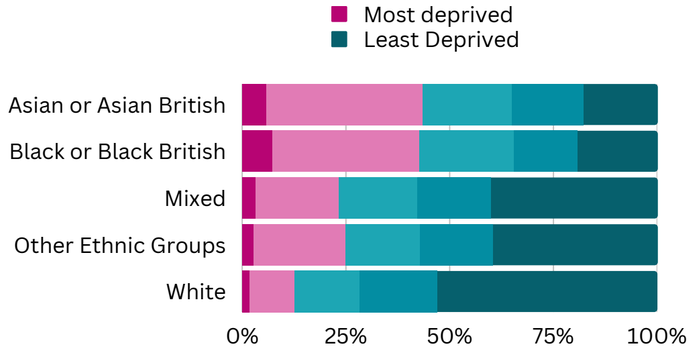
	% from BAME ethnicity groups	% living in deprivation (IMD deciles 1-4)	% over 65	% in households of 5+ people
Bracknell Forest	11%	4%	14%	26%
North East Hampshire and Farnham	11%	13%	17%	28%
Royal Borough of Windsor and Maidenhead	16%	5%	17%	32%
Slough	61%	61%	9%	52%
Surrey Heath	12%	7%	18%	28%
Whole population	23%	19%	15%	34%

Bracknell Forest ⬡ North East Hampshire and Farnham ⬡ Royal Borough of Windsor and Maidenhead ⬡ Slough ⬡ Surrey Heath

Frimley population insights: wider determinants of health

BAME cohorts are 2.6x more likely to live in deprived areas

33.1% of BAME residents live in deprivation deciles 1-4 compared to **12.6% for White residents**. Some key communities with known health inequalities are much more likely to live in deprived areas. For example, the **Gypsy Roma Traveller** community is almost seven times more likely to live in the most deprived areas. Another example of this disparity can be seen in the **Nepalese** community where it is three times more likely.



56k residents are at risk of **fuel poverty**

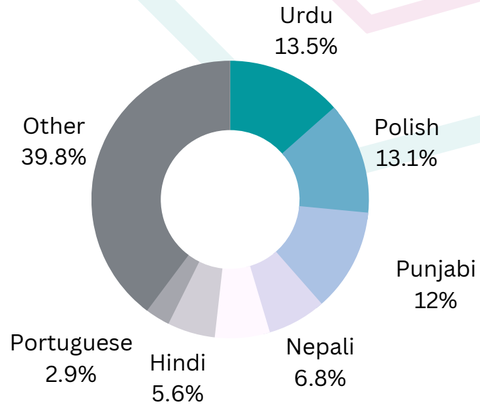
These patients are living in deprived areas and poorly insulated homes

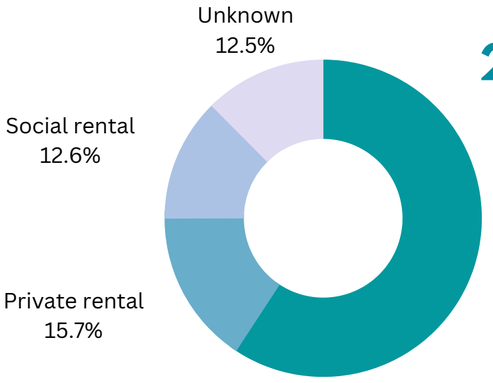
1.4% (700) have significant health issues
17.1% (9,500) have moderate health issues
76.5% (43,000) are generally healthy

There are 122 different spoken languages in our population

98,000 residents in our ICS do not have English as their main spoken language, the most common are **Urdu**, **Polish** and **Punjabi**.

Language barriers can impact a persons' ability to access and navigate health and care services





28% of the population are in some form of rented accomodation

10.6% of the population are smokers

7.5% medium to high alcohol consumption

In areas of deprivation we see a higher prevalence of smoking and obesity (but lower alcohol consumption). Non-white ethnicities tend to have lower alcohol consumption and are less likely to smoke (or have COPD). Smoking and alcohol rates are based on what is reported in GP records.

5.8% of the population have a BMI over 35

Frimley population insights: deprivation, ethnicity and disease prevalence

There is a strong association for **Diabetes, COPD, Heart failure** and many other conditions with deprivation. We also see lower prevalence rates for Cancer and Atrial Fibrillation which could reflect under-diagnosis.

On average, we see many conditions are between 1.5-2.5 times more common in deprived areas versus affluent areas after adjusting for age and sex of the populations

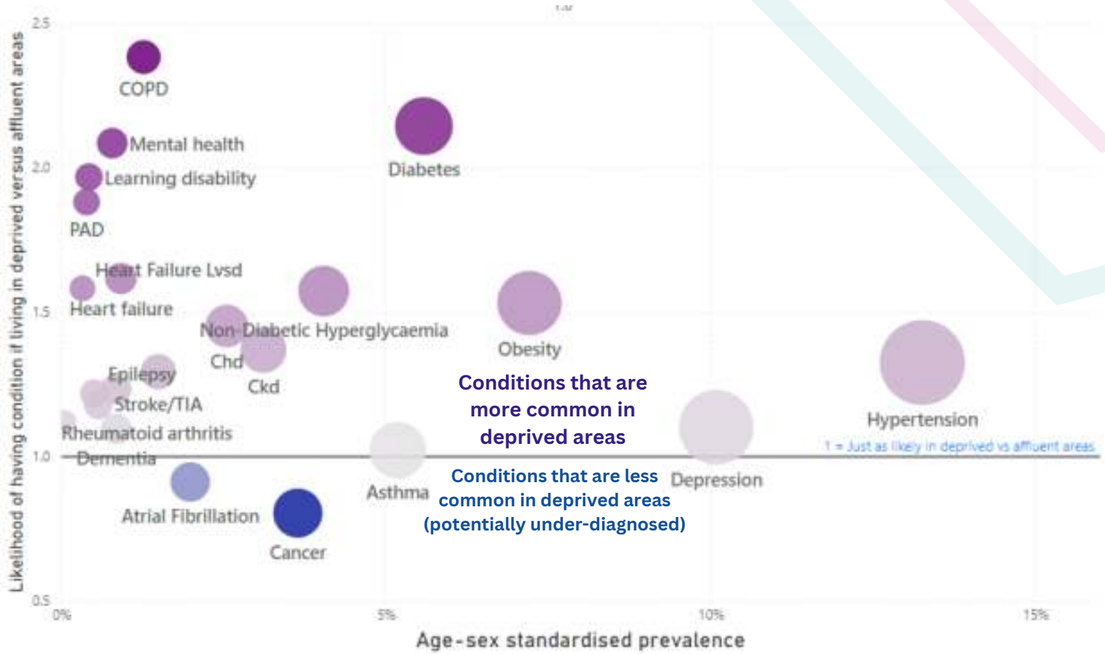
When looking at **ethnicity data** we notice the following:

- Asian / Asian British notably higher for Diabetes, Non Diabetic Hyperglycemia and Coronary Heart Disease (CHD), lower for depression, COPD and Atrial Fibrillation
- Black / Black British notably higher for Diabetes, Hypertension, Chronic Kidney Disease(CKD) and Obesity, lower for COPD, Depression and Atrial Fibrillation

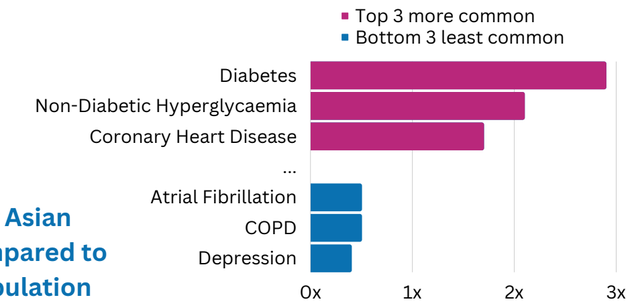
Slough compared to other parts of the system is **younger, higher % BAME, more densely populated** and **multigenerational households** and **more deprived.**

Adjusting for age and sex, **Slough has significantly higher prevalence of a wide range of conditions and risk factors.** There are strong associations between deprivation, ethnicity and prevalence of conditions such as diabetes and hypertension.

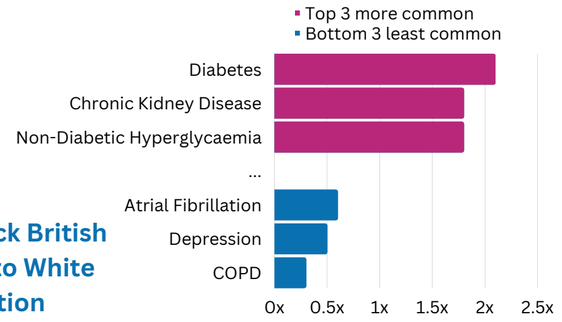
Increased prevalence of chronic diseases lead to **health inequalities** as well as disproportionate risk of impact from community transmitted conditions such as Covid-19.



Asian or Asian British compared to White population



Black or Black British compared to White population



Frimley population insights: cancer, diabetes, hypertension

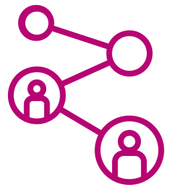
Those in the most deprived population have a lower percentage of **cancer referrals** made from all sources including National Screening programs and GPs, compared to the least deprived population (quintile 5). A greater percentage of diagnosed cancers are referred from Consultants or AE departments for deprived cohorts. This can mean cancers being detected at a later stage.

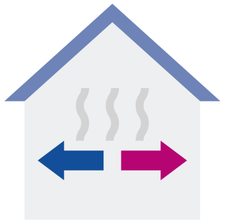
For certain care processes such as **cervical screening**, achievement is lower within the 20% most deprived population, which could suggest more effort is needed to reach these communities. For care processes such as **BMI and blood pressure reviews**, there is greater achievement in the more deprived population.

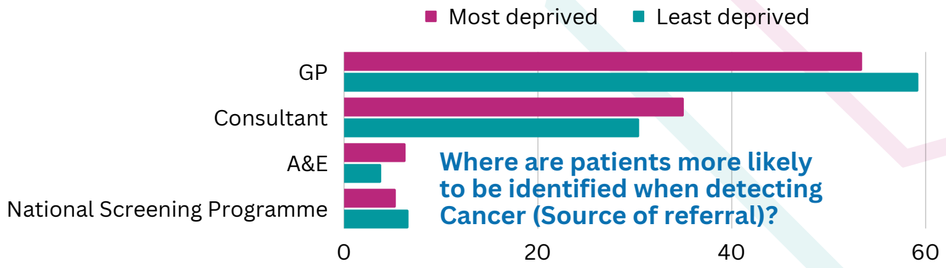
Control of **Diabetes**, however, in the Core 20 population deteriorated the most during the first year of the pandemic. The proportion of patients with **HBA1C** <=58 fell from 61.2% in Nov 2019 to 57.4% in Nov 2020. It is now improving but still below pre-pandemic levels.

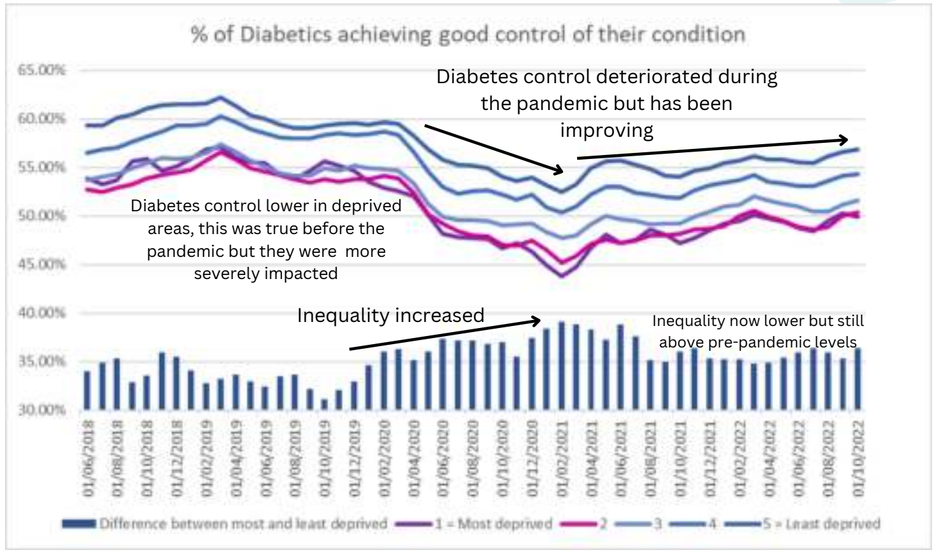
This deterioration was not seen as strongly in the least deprived population, and we now have a larger variation in control of diabetes compared to pre-pandemic.

In Frimley, we have been very focused on **improving detection, monitoring and treatment** of hypertension and diabetes. By utilising a wide range of local innovations we have seen a very encouraging return to growth in achievement of these indicators in Summer 2022.









Trend in proportion of patients with a recorded HBA1C with a value <=58

Throughout the Summer of 2022 a **Blood Pressure Bus** visited various sites across the system. Trained professionals were able to offer testing in local community settings. They also offered advice, began treatment as required and entered test results directly into digital patient records – checks included: Pulse, BMI and Smoking applying 'Make Every Contact Count' principles.

The bus visited 16 locations across Frimley and reached over 1200 people

Bracknell Forest ⬡ North East Hampshire and Farnham ⬡ Royal Borough of Windsor and Maidenhead ⬡ Slough ⬡ Surrey Heath

Strategic ambition one:

Starting Well

The purpose of **Starting Well** is to work towards **improving outcomes** for children and families. The plan is to work closely with communities across our population by engaging effectively with community groups, voluntary sector organisations and families. Our aim is to better understand the driving factors behind differing health outcomes and particularly barriers to opportunity and healthier choices, and improve **equity** across Frimley, taking a **co-produced, asset-based** approach to make a positive impact.

Our stakeholder events highlighted a number of areas of focus, particularly the pre-conception and early years and our agreed priorities are **vulnerable children and families** and **childhood obesity.**

By promoting the **habits of a healthy family** we aim to maximise the many opportunities that health, education and care professionals have to interact with families and **influence behaviour** including diet, oral health, supporting breast feeding and reducing smoking, particularly smoking in pregnancy.

We want to **build on the existing resources** that families and children have available, reducing confusion by having a 'single front door' and developing an accessible suite of tools, translated and available for all of our families.

We want to **work with places** which understand their population and can build on existing local initiatives.

Starting Well

Achievements

The **Equity Plan** is a key foundation for Starting Well. The detailed analysis of population and workforce highlighted differences relating to ethnicity and deprivation, for example that women in Slough are half as likely to be taking folic acid during pregnancy as women in Bracknell. Our workforce who are from Black, Asian and minority ethnic backgrounds are less likely to be represented in higher paying roles and over-represented at more junior positions. We worked collaboratively with our Maternity Voices Partnership holding focus groups with local women in Slough and Rushmoor to co-produce the Equity Plan and we are now starting to implement this by:

- promoting cultural awareness, ally-ship and being an active bystander
- planning a series of communication & engagement events for women and families in Slough
- Reviewing and improving resources and use of translators to ensure all women and families can access care

Building on the successful **Innovation Fund** programme we developed a Children, Young People and Families innovation fund with community groups and voluntary sector organisations who work with children and young people. This provided an opportunity to share insight, support and learning with this cohort of community groups and a networking forum.
The 17 projects which were funded included:

- Chalvey Action, Food and Fun family events
- Thames Hospice family days for bereaved children and families
- Projects creating green spaces, wildflower and vegetable gardens

The development of the **Frimley Healthier Together** website has created a single front door for digital resources for both families and professionals, coupled with the Maternity Website we have a comprehensive library of information verbally translatable through ‘Recite Me’. In addition successful campaigns and resources have included:

- Ready for Pregnancy and Parenthood -started in Frimley and expanded across the South East. Physical translated resources developed and shared through community venues
- Solihull parenting modules, translated in a variety of languages - with over 2000 registered learners
- Maternity personalised care app launched in October 22 has over 1200 downloads. Enabling personal decision making and signposting to wider resources

The focus on **Healthy Behaviours** has included:

- Development of a Frimley wide **‘Healthy Weight’** group bringing together place leads to share their initiatives and map existing assets. Healthy weight was a core priority for Starting Well. National Child Measurement Programme data has demonstrated high levels of over-weight and obesity particularly for children living in Slough and Rushmoor.
- We are delivering **‘This Mum Moves’** training across our 5 Health Visiting and our maternity teams and bringing together a focus on Gestational Diabetes within Maternity.
- Our continued **Smoke-free pregnancy collaborative** initiatives have resulted in the lowest smoking in pregnancy rates in the South-East. We work closely with the specialist stop smoking services and are implementing a new offer for women in line with the Long Term Plan

During COVID we know that women often felt isolated after pregnancy, and we continue to work across Public Health, Health Visiting and Midwifery teams and closely with our Maternity Voices Partnership and are developing antenatal and peer support for families on the areas which worry them, such as breast feeding support.

The **Frimley Maternity Plan app** was co-produced with local midwives, women, and the Maternity Voices Partnership, and is being used by women who are pregnant and receiving their maternity care from Frimley Health.

1148 downloads in the first 4 weeks after launch

The app is a space to help record what matters to the user, plan their pregnancy, explore pregnancy choices, access useful links and resources and plan ahead for discussion with their care team.

Starting Well

Priorities

The development of the new ICS Children and Young People (CYP) portfolio transformation plan marked a clear **call to action**. As the ICS looks forward, we are raising the importance of our work to improve the health and wellbeing of children and young people.

There is a clear case for greater and faster transformation of CYP care and services:

- A quarter of our population are CYP
- We know that there is variation in the care of CYP and their outcomes that we must tackle
- The pandemic has widened existing health inequalities and worsened the health of our CYP, particularly their mental health
- The cost-of-living crisis is affecting low-income households and puts the health of children at greater risk
- The health and care services that we provide to CYP are struggling to meet demand

Our call to action comes with optimism about what we can collectively achieve. It has been shaped and developed by the key partners and stakeholders who will be instrumental in delivering it. They are committed to ensuring this plan succeeds and transforms the lives of Children and Young People across Frimley. The ICS has invested in a small team of experts to help lead its delivery, in partnership with our 5 places, voluntary sector, local authority and service leads.

This is an ambitious programme, shaped and agreed by the Place and CYP leads from across the system, with the support of colleagues in neighbouring ICSs. Their commitment is to work together to deliver this programme, alongside their day-to-day responsibilities for managing and leading Children's services across the ICS. As part of the Children and Young People portfolio review and subsequent strategy, a clear direction of travel and programme has been developed with 5 areas of focus, which includes Starting Well.

1. Starting well
2. Transforming neurodiversity services
3. Transforming CYP mental health
4. Supporting children with life long conditions
5. Improving SEND

Starting Well Priorities include:

- Addressing health inequalities through a focused approach to meeting the needs of vulnerable children who experience deprivation and poverty across our communities, including the newly published Core20PLUS5 framework for children.
- Babies and Children in the first 1001 days through to primary school, ensuring that every child is "school ready" for when they are ready to enter the education system
- Supporting and strengthening partnerships around health visiting and school nursing.

Children and young people in Frimley

Across Frimley ICS there are around 8,000 births a year

Slough has the highest fertility rate in England

1500 of those aged 0-19 are known to smoke

More than 8,000 children aged under 10 are currently living in deprivation and in poorly insulated homes

The prevalence of mental health has increased during the pandemic. 16% aged 5-16 now estimated to have a disorder, compared with 11% in 2017

Approximately 15% of pupils have a special educational need

26% are from a BAME background. Ethnic diversity varies greatly. (13% in Bracknell Forest, 60% in Slough)

Starting Well

Benefits and sustainability

Children get the very best support for their health and care needs through the first 1001 days of life, beyond and through to primary school, enabling them to make the most of opportunities to thrive and flourish. We are committed to ensuring that childhood inequalities will be identified and addressed including those highlighted in Core 20 plus 5 framework for children (see adjacent panel).

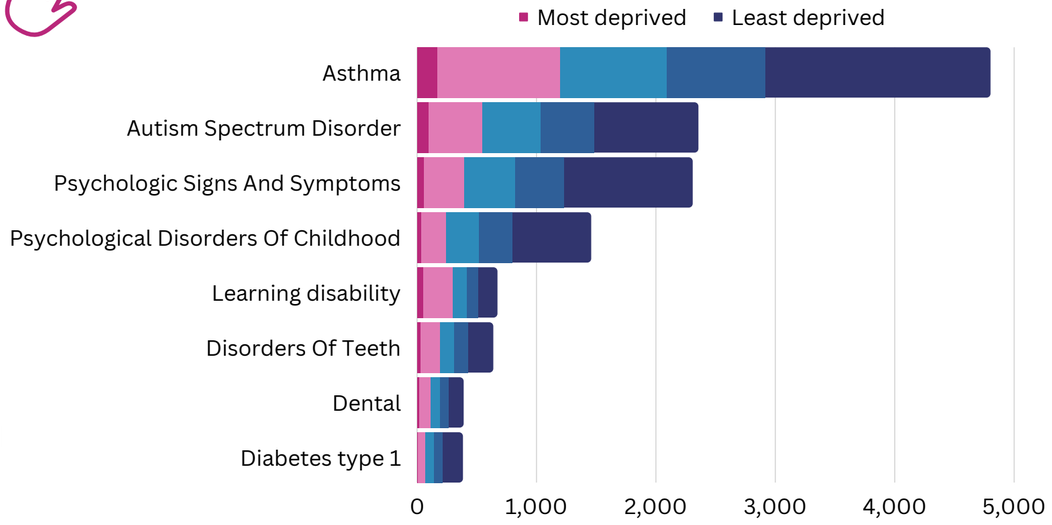
There will be a joined up leadership approach across local authorities voluntary sector and health, connected with places to share initiatives and good practice. Our collaborative endeavour will enable consideration of options to optimise and support public health nursing workforce.

Starting Well will work alongside interdependent programs to deliver the following benefits:

- Local Maternity and neonatal System which will be delivering our perinatal Equity Plan focusing on resources, service delivery and workforce.
- Physical Health CYP-addressing conditions highlighted in the Core20plus5 framework for children
- Mental health CYP-addressing inequalities in access to CYP services

The benefits will include:

- Collaboration where partners can share good practice and collectively influence change
- A thriving and connected community and voluntary sector offer for families
- Improvement in health outcomes including healthy weight rates
- Supported families
- Accessible digital and physical translated resources including the Healthier Together platform
- Better understanding of public health nursing workforce challenges and consideration of opportunities to transform



174k

Children in our ICS

33k

Children living in our most deprived areas (IMD deciles 1-4)

11.7k

Children with conditions mentioned in the Core20Plus5 strategy, of whom 2.6k are also deprived

Strategic ambition two:

Living Well

The long-term sustainability of our health and social care system depends on people living longer in good health. Our aim is to identify and target the cohorts of people where physical and mental health problems can be prevented or outcomes improved with a focus on deprivation, inequalities and those with most complex needs. Data shows we have stark intra-area health inequalities, with poor, and worsening, health and wellbeing outcomes in our more deprived communities and other groups.

We want to help tackle the root causes of lifestyle behaviors, working together, to provide personalised support to address them. Co-productions with our communities is an aspiration that shifts to a culture of prevention and self-care. We need to move away from a system that simply treats illness but works towards prevention, helping to create the right conditions to support residents and patients to live longer in good health. Health is about more than healthcare alone we must work in partnership with residents, local government, voluntary sector and wider stakeholders to reduce health inequalities through addressing the wider social determinants of health.

The challenges presented by the pandemic also meant that existing health inequalities have been compounded, those who are at risk of poor outcomes with long term conditions or health behaviors that are amenable to change. The Ambition therefore supports our general aims around helping develop strong, resilient and healthy communities. A system focus on effective primary prevention measures is crucial and a systematic and coherent preventative approach is necessary – not just looking at interventions that focus on individual behaviours but delivering a strategic approach to healthy places, strengthening and connecting into communities in a better way.

We aim to take a Population Health Management (PHM) approach to embed decision making based on evidence, across the development and monitoring of our programmes.

Individuals need strong stimuli to support their own health improvement and an environment that makes it possible. Places need to engage robustly with their communities about why living well is more challenging and what can be done to improve it. We will need to harness behavioral science and social messaging to support such changes.

Our ambition is to Improve the health and wellbeing of the poorest and sickest fastest.

Living Well

Achievements

To make a difference to health inequalities, those communities who are most affected need to be central to everything we do. Different solutions are needed for different communities with support for the most vulnerable and excluded people. We need a two-way approach: engaging with communities to share key public health messages and information, but also listening and learning from the communities themselves to understand their concerns/needs/views on how we can best partner with them and consequently bringing that learning back in a timely way to enable further responsive change.

Cardio Vascular Disease (CVD) Prevention

- Places are developing a tailored partnership plan to tackle hypertension (with links to NHS Health Checks and other modifiable risk factors)
- Building on our campaign work, targeting groups at a higher risk of CVD (Measurement month, Hypertension Day, Know Your Numbers, Smoking)
- Videos, leaflets, posters and Communications toolkit developed for hypertension
- Developing different community hypertension pilots including a Pharmacy BP Service
- Remote monitoring of Blood pressure directly entered into the patient's clinical record
- Aligning to Core20PLUS5, to accelerate and augment implementation of the approach
- Making progress against NHS LTP high impact actions for stroke & cardiac care

Lifestyle

- Healthy Conversations - Making Every Contact Count
- Embedded the NHS Digital Weight Management Programme. Our ICS has the greatest uptake across the country.
- Whole Systems Approach to Obesity (WSATO) workshops delivered to tackle drivers of obesity
- Working closely with Sports Partnerships to address physical inactivity
- Smokefree Group established to reduce smoking prevalence and implement the NHS Long Term Plan objectives relating to tobacco (Inpatient and Maternity Tobacco Dependency Service)
- Community Stop Smoking Services
- Alcohol hospital specialist service and brief interventions
- Community Asset Based Approaches in Local Authority to support communities

Benefits already being seen and the impact on our communities:

- Closer collaboration and partnership working with Health, local government and the Voluntary, Community and Faith Sector will facilitate a more holistic, joined up approach to managing the health and wellbeing of all residents
- An improvement in health literacy and outcomes resulting in better prevention and self-management
- Our most vulnerable cohorts and populations have improved physical and mental health outcomes
- Strengthening communities through recognising, identifying and harnessing existing 'assets' - building trust, networks in the community
- Ensure people have the skills, confidence and support to take responsibility for their own health and wellbeing

Identified Outcomes:

- Health and Care Strategies across places, will align to the Ambition, bringing people together against an evidence base and a prioritised set of ambitions
- Strengthening the ability of the NHS to deliver prevention activities, e.g. workplace health, the influence of Anchor Institutions
- Residents feel more engaged, which supports delivery and helps improve outcomes and quality of life for people and communities
- An improvement in health literacy and outcomes resulting in better prevention and self-management
- Increased evidence-based decision making to improve health and act on inequalities
- Improved health outcomes of the most marginalised e.g. Sustained smoking cessation, healthy weight and physical activity
- Improved detection and management CVD risk factors
- Improvement in physical literacy
- Prevention of other non-communicable diseases
- Increase in the number of patients who achieve a 4-week quit that began in hospital

Living Well

Priorities

Despite the challenges of Covid, the Living Well ambition has made strong progress, building on the momentum of our previous partnership work together to hone in on those populations who can most benefit from this approach.

The work of the partnership to systematically identify specific population health improvements, most particularly with regard to **hypertension, obesity and tobacco** will make a step change in the long-term population health for local people and their families. The learning we have generated during the last three years will continue to be an important foundation for our future aspirations of working together, as we seek to scale and spread our interventions in order to reduce health inequalities and improve healthy life expectancy.

A system focus on **effective primary prevention measures** is crucial and a systematic and coherent preventative approach is necessary – not just looking at interventions that focus on individual behaviours but delivering a strategic approach to healthy places, strengthening and connecting into communities in a better way.

The Living Well ambition is delivered locally at each 'Place' but within a collective systematic approach.
9 Priorities included in the 'Living Well' Framework:

1. Smoking
2. Education, Employment and income deprivation
3. Reducing Health Inequalities
4. Obesity (incl. healthy diet) and Physical Inactivity
5. Family/social support
6. Targeted lifestyle support for those with the greatest need
7. Built environment
8. Healthy Hospital Strategy
9. Air Pollution

We will be continuing with our 3 main priority areas (**CVD Prevention, Healthy Weights, Smoking**). The priorities give a rounded mix of primary, secondary and tertiary prevention interventions. They contribute to the outcomes expressed in the Living Well framework and help address health inequalities.

Places have indicated other priorities from the framework, and that will continue, and these are priorities we will focus on together, collaboratively; the common thread across the 5 Places, to maximise the opportunities and impact.

- **Focussing on Health Inequalities** - to improve and reduce variation in health outcomes across disease areas in our system aligning to the CORE20PLUS5 approach
- Support Health Improvement **behaviour change programmes** across the ICS
- **Healthy Conversations** – opportunistically encouraging individuals to consider their lifestyle and health with a view to identifying small but important changes.
- Identify communities and priorities in common with other ambitions particularly **Starting Well** and **Community Deal**
- Support **community engagement** with groups with poorer health & wellbeing outcomes to understand barriers and **co-produce solutions**
- Develop our capability to co-produce solutions to the **wider determinants** that cause poor lifestyle behaviours, which will be enabled by the Community Deal
- **Social Prescribing** to support vulnerable people, linking with community hubs.
- Ensure addressing **prevention** and **inequalities** is everybody's business
- Focus on addressing **equalities and inclusion** issues to ensure uptake (wider preventative interventions) is maximised in all communities
- Roll out **Tobacco Dependency programme**, to ensure the provision of a resilient, sustainable programme that supports more people to quit smoking.
- Renewed commitment to **smoke free sites** across our services and develop a tobacco control and e-cigarette strategy
- Develop a Frimley ICS **Healthy Weights Strategy** and action plan and delivery of the Health promotion campaign work
- Enhance **Physical Activity awareness** in secondary care – moving towards activity prescription in clinical practice and training for staff
- Explore **staff offers** of support around: Smoking, Healthy Weight and hypertension

Living Well

Benefits and sustainability

- Better health outcomes and lower health inequalities and variation across our population
- Preventing people from dying prematurely and a reduction in preventable ill health
- Improved design of our programmes to increase access reduce inequity focusing on health promotion, prevention, and the wider determinants of health
- Health and Social Care services will be co designed to improve access, experiences and outcomes, for these communities
- Intervening early to reduce prevalence and severity of long-term conditions and to manage them more proactively Promoting self-care and taking responsibility for your own health for those that can
- Improved health status of the population by raising awareness of health risks, availability of services, to change behaviour
- Increased evidence-based decision making to improve health and act on inequalities
- A community approach to promoting healthy weight in children, young people and families helping our communities live healthier and more active lives
- Engaging with communities to maximise use of community assets
- Increased physical activity and improved healthier eating as part of treatment regimens working towards personalised centred goals
- Better support for under-served and vulnerable groups to improve their health and improve equity - Building trust, networks in the community
- Health and Care Strategies, will align bringing people together against an evidence base and a prioritised set of ambitions
- Delivery of work based prevention activities to improve staff health and wellbeing and reduce staff absence
- Contribute to the prevention of other non-communicable diseases
- Sustained increase in referrals to existing community stop smoking services and the number of patients who achieve a 4-week quit

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

Strategic ambition three:

People, Places and Communities

In 2019 this ambition started as the **Community Deal,** inspired by the work in Wigan and elsewhere in the country to focus on a new relationship with local communities. Over the last three years, this work has evolved and taken on a more local direction. In order to better reflect the work being undertaken we propose to change the ambition name to 'People, Places and Communities'.

Through the work of this ambition, Frimley Health and Care ICS has started to **build different relationships** with its communities and residents, as well as with its own staff, to work towards Creating Healthier Communities through relationships at neighbourhood, place and system level. More than anything this ambition is about **how we work with communities**, as an enabler to deliver on the other five ambitions to achieve the outcomes we have set. Collectively we will bring together local authority, voluntary sector, health, and wider partners such as housing , education, and employers to tackle health inequalities using population health management, data insight and focusing on the wider determinants of health to bring about **practical and tangible improvements** in the health and wellbeing of the people who live and work here.

Building on the expertise of our partners we will create **inclusive relationships** with communities across our diverse system at grassroots level, to harness individuals' and communities' strengths and assets through co-design and co-production finding solutions for our communities to help them live healthier lives, taking more responsibility for their own health and wellbeing. Fostering innovation through a range of **place-based initiatives** which support the population, linked with early intervention, reducing disparity, or focusing on preventative health and social care.

The ambition also supports the commitment to creating a system where **people are treated as individuals** by professionals they trust, and where people with 'lived experience' are often best placed to feedback to services on what will make a positive difference to their lives. It ensures that the voice of people with lived experience is integral to the development and delivery of personalised care, modelling the shift in relationship and supporting the culture change required to be people centered.

People, Places and Communities

The ambition to build new relationships with local people and communities, recognises that real change in the quality of people's lives cannot be achieved by organisations alone – everyone has a role to play. Over the last three years the 'Community Deal' ambition has focused on the principle of "doing with," not "doing to" people, encouraging people, families, and communities to take more responsibility for themselves and each other so that everyone can live in healthy and thriving communities.

Our original strategy was published just before the Covid-19 pandemic, and it is impossible for us to look back and understand the changes that have happened since then without understanding this context. Early in the pandemic, and particularly during the first lockdown, there was a blossoming of community support and activity aimed at protecting everyone in the community, ensuring people's basic needs for food, medicines and care were met. supporting people to remain socially connected to avoid isolation and loneliness. As the pandemic progressed this translated into more formal volunteering through Covid vaccination clinics, providing vital support during the dark days of winter to ensure our most vulnerable communities were protected. Across our population vaccination uptake was high and although new strains of Covid emerged that were more transmissible but less severe, life for the majority returned more or less to normal but being mindful that for those who have family and friends or are living with Long Covid, this may not be the case. However, we are still understanding and learning to live with the longer-term impact of the pandemic, on public health, and the wider determinants of health which fundamentally define and shape our quality of life.

The Pandemic has impacted the delivery of this ambition and has led to the emergence of new and changed needs across our populations. With the increasingly constrained public finances, there has never been a greater need to focus on prevention and early intervention and encourage individuals to take more responsibility for looking after themselves and each other, so that we can live in healthy and thriving communities

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We aim to deliver this ambition by:

- Promoting the principle that everyone has a part to play in building and creating healthier communities concentrating on improving health and wellbeing.
- Delivering the narrative for the system on what we aim to achieve and how.
- Building on our progress on developing and spreading population health management approaches.
- Drawing in a wider range of partners through our place-based partnerships, to better coordinate and enrich the support we all provide to our communities.
- Working with local communities to identify and build on existing community assets at neighbourhood and place level.
- Developing effective co-production and co-design methodology and capability across all partners of the system
- Empowering staff to have a different conversation with individuals and communities.
- Giving individuals and communities the freedom to innovate, and design offers and services that meet their needs, supporting independence and what people do for themselves.
- Delivering personalised care by building new relationships and shifting the power in decision making.

By developing this approach, it will enable the delivery of the Starting Well and Living Well ambitions.

NHS Charities Community Partnership Grants and Innovation funding supported a range of place-based initiatives that foster the concept of community/ voluntary sector support to build a stronger co-production approach. The funding was linked to supporting early intervention, reducing inequality, or focusing on preventative health and social care, with a particular emphasis on diversity within the population.

£500,000 total funding in 2021-22 supporting 60 projects across Frimley

People, Places and Communities

Achievements

As an enabler, the Community Deal has been deployed in diverse ways across the five places and within their neighbourhoods, working with other programmes like Starting well, living well, NHS Charities Community Partnership Grants and Personalisation, to have a different conversation and engagement with residents and communities.

The last two years have been challenging due to the pandemic and has had devastating impacts on individuals and families. We have seen people spontaneously volunteering to do shopping for their neighbours, collect prescriptions or pick up the phone and have a conversation and because of that, vulnerable people were identified and supported before their needs escalated into crisis.
Each place has engaged with communities at various levels and in diverse ways based on the needs emerging from the pandemic community engagement. Examples across the system include:

- Community Based Assets workshop focus on poverty, children and young people and loneliness
- Development of community champions and #One Slough
- Royal Borough Windsor and Maidenhead creating #RBWMTogether with residents engaged in World Cafes identifying resident solutions through asset-based community development methods
- Bracknell Forest Thriving Communities programme focusses on collaboration: creating better outcomes through better partnerships to deliver improved health and wellbeing outcomes and reductions in health inequalities
- Healthier Communities in North East Hampshire and Farnham in conjunction with the local district and borough councils focusing on hypertension, mental health, and physical activity.
- Building local capability, learning with partners, on the concept of a “community deal.” through collaborative and creative work with communities with the poorest health outcomes in Surrey Heath
- Place are aligned with the Health and Wellbeing Strategy to enable empowered and thriving communities, and to ensure a cross-cutting approach on co-production, Co-design and Community led action.
- A Discovery Learning Programme for primary care, community members and local partners to create the conditions for Health Creation by working as equal partners with local people and focusing on what matters to them and their communities.
- Introduction of the Collaborative Practice Programme using population health management to understand and manage demand of services by our ‘frequent attenders’ and those suffering the greatest health inequalities to offer a service that meets their needs

Key areas of development across the system:

- The narrative setting out what the Community Deal is and what it means in Frimley is on the Frimley ICS website.
- The Community Deal Framework to assist and support places has been written and is regularly updated with national and local good practice.
- Personalisation is being incorporated into the work with Communities and how community groups can support health and well being
- Working with Healthwatch, voluntary sector, local authorities, primary care networks and providers to engage communities to reduce health inequalities
- A video has been created capturing the work as part of the Community Deal and how the NHS Charities projects have enabled the start of these different conversations.

The **#OneSlough** initiative was created at the start of the pandemic in March 2020. Bringing together, the voluntary, and business sectors and faith communities, with Slough Borough Council, resources and skills were combined, to deliver essential services to Slough residents. Together they met on a weekly online call, to work out the logistics of this huge endeavour.

#OneSlough

An incredible **12,273 food parcels and 708 prescriptions** have been delivered by volunteers to the vulnerable; a massive achievement by everyone involved.

Whilst food parcels and prescriptions are still necessities for some, other needs have surfaced. Domestic violence, unemployment and poverty have increased in the town and as a result several projects, funded from donations received by Slough Giving, have been established.

People, Places and Communities

Achievements

NHS Charities Community Partnership Grants funding supported a range of place-based initiatives that foster the concept of community/voluntary sector support to build a stronger co-production approach. The funding was linked to supporting early intervention, reducing disparity, or focusing on preventative health and social care, with a particular emphasis on diversity within the population.

The outcomes of these projects include:

- Individuals being supported to become more independent and integrated into communities supported by the VCS. including Cares support and signposting.
- The Wellbeing Circle project has been able to create a trusting and collaborative partnership across local authority, health, and the voluntary sector supporting individuals health and wellbeing at home through a personalised care approach.
- Supporting culture events with young activists against racism linking public health messaging to diverse cultural, faith and differences spiritual perspectives
- Promoting key health messages linking with the Diversity Calendar
- New links established with underserved communities e.g., Polish/ Gypsy Roma Traveller
- People are digitally connected with families and others reducing loneliness and Isolation
- Over seven hundred individuals are registered as community champions to support BAME population
- A community Innovation Fund established across places to support local community projects.

By working in close partnership, we will be able to create more opportunities for shared ownership across different work programmes to better reduce health inequalities.

Priorities

The impact of the pandemic has been felt by everyone and it is important that we understand the difficulties people are facing, whether they be related to health, housing, finances, or family. Building on the expertise of partners, voluntary sector, and charities we will work together to make fundamental change to collaborate with communities to make healthier choices. We also recognise that there is additional work which our partnership can do to better support Unpaid Carers which are a critical component of our health and care workforce.

The future priorities for this ambition are:

- Supporting the implementation of the South East Mental Health Compact which seeks to transform mental health services at scale and pace, including redefining the relationship between mental and physical care
- Creating relationships with all the Voluntary Community Social Enterprise (VCSE) organisations to be key strategic partners in shaping, improving, and delivering services, to tackle the wider determinants of health and create community asset partnerships
- A clear approach to engaging with our population at place and system levels, including representation at place-based partnerships and the ICS partnership to inform decision making
- Ensuring all of our diverse populations are represented with the creation of an ICS inclusivity framework
- Exploring citizen leadership and creating opportunities to develop decision making in our communities
- Using data and insight to focus on where the biggest impact can be made – for example children and families or those most affected by the increase in the cost of living and housing with fuel poverty
- Using the expertise in local authorities to develop a cross-cutting approach on co-production, co-design and promoting independence and sustainability to enable empowered and thriving communities.
- Identifying and supporting innovation through small scale grassroots community projects using the learning of the Innovation Funds project
- Continually looking for ways to measure success impact and outcomes in conjunction with the starting well and living well ambitions
- Collaborating with our communities to recruit those with lived experience to support a co-produced offer supporting and developing peer leaders for the system
- Working with partners to make best use of funding and joint working opportunities to deliver our commitments around the Serious Violence Duty
- Work with partners and those with lived experience across the system to develop a framework and policy as how to engage with those with lived experience at all levels with the ICS
- Support from Frimley Academy to provide opportunities for training and development of our workforce to hold community conversations and co-produce plans for improvement
- Sharing and spread of good practice in the diverse ways of working. to support the community deal approach.
- Working with people and communities around developing our shared approach to Palliative and End of Life Care, supporting people of all ages to die well and in a way that supports families and communities better cope with these difficult times.

People, Places and Communities

Benefits and sustainability

The ICS aspiration is for people to live their lives to their fullest potential. To achieve this, it will require us to create new ways of working, to work flexibly, to invest in models of delivery, and to be brave enough to actively target resources to where we can make the biggest difference for local people. Key benefits include:

- The system understands and is working towards the ambition at all levels
- We have an effective co-production methodology and capability at all levels across the system
- Better outcomes for the most vulnerable
- Understand unique aspects of each community population and their priorities
- Understand population assets, needs, and priorities
- Targeted wellbeing offers that meets local needs and priorities
- Communities feel empowered to have a voice and make decisions that are right for them
- Strong relationships with organisations and the VCSE
- Good conversations with all our communities.
- Using the data and insights to target change with he the wider determinants of health
- Equity of offer across the system.
- Empowered communities with improved capacity to look after themselves and each other
- Ultimately resulting in mitigation of the demand pressures and financial constraints across the system

People and Communities Strategy

Frimley Health and Care ICS has a strong reputation for working with people and communities, built on trust and long standing partnership work with a wide range of stakeholders. We recognise that insight underpins and supports transformation. Delivery models are changing, and public involvement is essential. We are committed to delivering the best possible health and wellbeing outcomes for people who live within our local communities. This means adapting to new ways of working, ensuring a local focus but with the additional benefits of support, sharing good practice and learning across our system.

"People and communities have the experience, skills and insight to transform how health and care is designed and delivered. Working with them as equal partners helps them take more control over their health. It is an essential part of securing a sustainable recovery for the NHS following the pandemic. The ambition is for health and care systems to build positive and enduring relationships with communities to improve services, support and outcomes for people."

Statutory guidance for working in partnership with people and communities, NHS England, July 2022

Frimley Health and Care is developing a system-wide strategy for engaging with people and communities. This draft strategy for Frimley has been built upon insights and experience across the system and engagement with key groups and communities including ICS/ICB Board, CCG and partner staff, Healthwatch and voluntary sector partners and key patient and community groups.

The draft strategy has been shared with NHS England and will be shared with the ICP with the expectation that further refinement and engagement activity will take place throughout 2023, to ensure we actively listen to communities as we establish new ways of working.

To watch a short film about the work of the Community Deal ambition please click the icon or scan the QR code.

Insight & Involvement Portal

To access more information about the People and Communities Strategy please scan the QR code or visit:

insight.frimleyhealthandcare.org.uk/peopleandcommunities

Strategic ambition four:

Our People

Workforce challenges in health and care have been talked about for years, but the scale of challenge in the last two years have been unprecedented. Partners across the health and care system are working hard to ensure we have the workforce we need now and in the future. We need to be clear where we best deliver through a system focus- where we are stronger together to resolve some of our most difficult and longstanding workforce challenges.

- We want to be known as a great place to live, work, develop, make a positive difference.
- We want all of our people to have the opportunity to be physically and mentally healthy, fulfilled, effective and flexible in how they work and what they do.
- We want to attract our local population to careers in our health and care system.

Our People

Achievements

Equality, Diversity and Inclusion
Within the Frimley system we are passionate about equality, diversity and inclusion (EDI). This provides a golden thread for all that we we do but we are particularly proud of our '**Melting the snowy white peaks**' programme. This recognises the under-representation of Black, Asian and Ethnic Minority nurses in senior roles, despite these staff representing over 20% of nurses. In partnership with Surrey University, we have explored, 'how can we better prepare nurses from Black, Asian and Ethnic minorities for career progression?' Nurses described a need to be 'better allies for each other'. We have provided a case study of the programme to demonstrate the positive impact our students tell us they have experienced as a result. Learning is shared with other professional students eg midwives, paramedics and medicine and also with other universities who are exploring offering the programme to their students.

Temporary Staffing
24% of the Adult Social Care workforce are on temporary (zero-hours) contracts. In the NHS, 4/5 registered nursing vacancies and 7/8 doctor vacancies are filled by temporary staff. Temporary staff are a hugely important part of our workforce. Our programme has been created to create a culture where temporary staff are welcomed – seen as essential and valued, where we recognise that people want flexibility and choice. Working as a collaborative, Frimley, BOB and Surrey Heartlands are improving processes, increasing productivity and strengthening how we deploy an adaptable workforce. Other partners will be joining this successful model soon.

People in Partnerships
Integrated care requires teams to work together. The PIP programme aims to support teams to strengthen collaboration across the system. Achievements:

- A leadership programme aimed at integrated team leaders
- A series of webinars led by Prof. Michael West on compassion and collaboration
- Supporting teams to have a 'Culture conversations'
- An integrated team diagnostic

Allied Health Professionals
AHPs are an essential core part of our workforce. The AHP workforce programme works across the system to strengthen recruitment, retention, transformation within primary care, and maximise clinical productivity. Achievements:

- Design and deliver the system AHP strategy – leading to improved AHP capacity through international cert and return to practice
- Increase placements by 255 in academic year 20-21 (84% uplift in placement capacity)

Just Culture, led by Berkshire Healthcare on behalf of the system, is an award- winning initiative which takes a fresh approach to promoting inclusion and compassion when incidents occur in the workplace. By improving understanding and increasing support to staff, disciplinaries reduced and staff survey scores improved.

This approach has saved over 600 hours of clinical time

Berkshire Healthcare take a 'Lead Investigator' approach across the Frimley Health system and provide highly trained, dedicated investigators for fact finding in disciplinary cases. Previously, clinicians were required to undertake investigations so this approach saves clinical time (600+hours) and improves the overall standard of investigation reports. The process encourages earlier resolution in cases resulting in reduced suspensions and disciplinaries.

Our People

Priorities

Workforce challenges in health and care have been talked about for years, but the scale of challenge in the last two years have been unprecedented. Partners across the health and care system are working hard to ensure we have the workforce we need now and in the future. We need to be clear where we best deliver through a system focus- where we are stronger together to resolve some of our most difficult and longstanding workforce challenges.

Our ambitions are aligned to the Frimley system strategy, and the initiatives we develop framed by the NHS People Plan.

We are undertaking a strategy refresh with our partners to agree our 'at scale' workforce transformation priorities – engagement and intelligence so far tells us we should focus on three target areas:

1. **Creating a joint workforce model for health and care – more connection, agility, equity and opportunity for our people, regardless of their employing organisation**
2. **Widening access to employment and keeping the people we have– working with our staff and our communities to remove barriers, truly listen to people to understand what they need to join us and stay with us**
3. **Strengthening partnership working and new models of care - Supporting our teams to drive transformation and to work in partnership to deliver high quality integrated care**

Many of our system programmes are truly making a difference. It is important to recognise what works well and use data to measure progress. It is also important to know when we need to take a different path. We will ensure everything we invest in has a clear purpose, is value adding and is transparently evaluated.

Our People

Benefits and sustainability

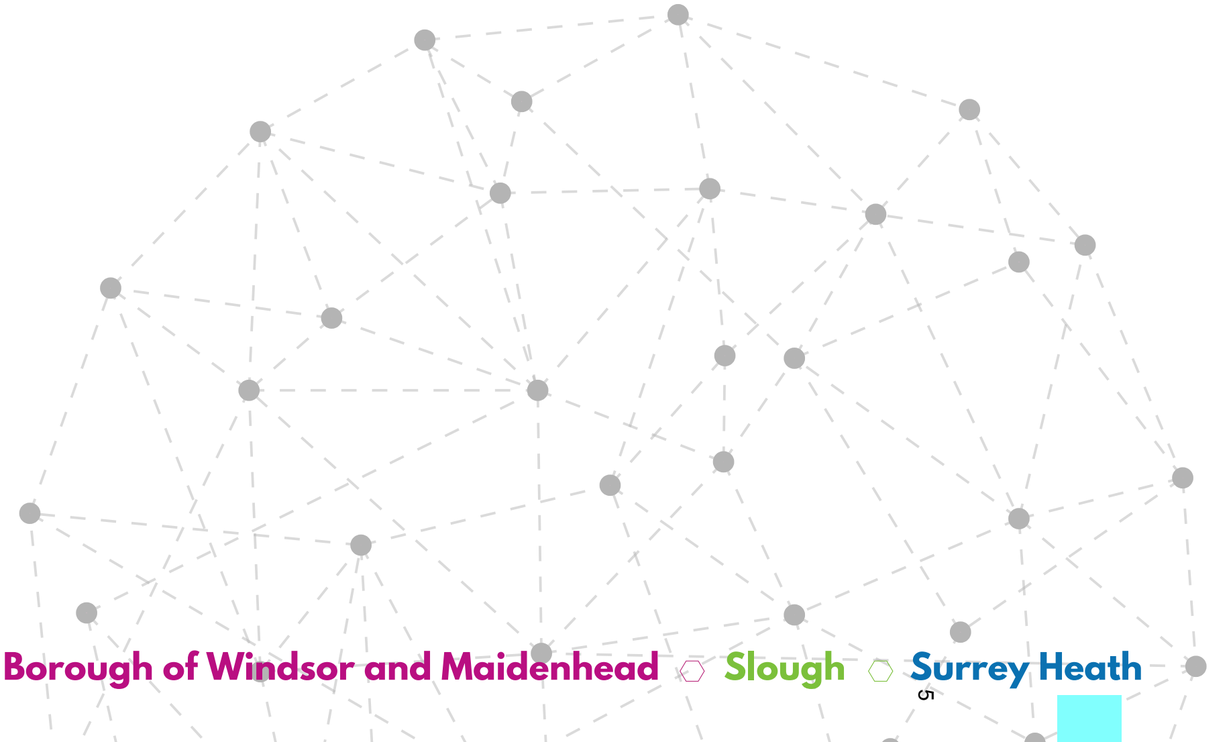
We have engaged with stakeholders across the system to find out what is important to them with regard to our People. They tell us we need to:

- Remove barriers to people accessing work or progressing
- Work more collaboratively as partners and better understand each other
- Improve parity between those working in health and those in care
- See all working or volunteering in health and care as valued and important
- Increase the diversity of our staff, particularly our leaders
- Better understand our communities and their employment needs
- Support the wellbeing of our staff, particularly as cost-of-living pressures rise
- Demonstrate care to each other and create compassionate leaders
- Create long term plans so that we have the workforce we need for the future

By focusing our system resources on our three target areas we will deliver or support initiatives which will:

- Reduce inequalities between our health and social care workforce – improving parity of terms and conditions, development opportunities and access to support
- Optimise our community assets to enable more people to access 'good work' through our Anchor Institutions programmes
- Improve our management of and support to temporary staff, extending our programme across the South East region and to primary and social care partners
- Strengthen our widening access and participation programme so that more people can join and progress within the Frimley Health and care system
- Retain and strengthen our Reservist workforce who volunteered to support the vaccination programme. Extend this across social care
- Reduce discrimination and achieve greater diversity in leadership roles
- Increase workforce capacity through local initiatives and international recruitment, creating robust workforce plans for the future
- Improve retention through; preventing violence at work, supporting health and wellbeing, enabling people to progress across health and care, embedding digital solutions and supporting staff with housing/cost-of-living challenges
- Enabling clinical leaders to redesign services and workforce models through our CLEAR programme
- Embed new roles such as Trusted Assessors to promptly assess hospital patients on behalf of care homes
- Support people across our system to be compassionate leaders who role model partnership working to deliver high quality integrated care
- Improve nursing and AHP attraction, retention and development through increasing placements, attracting and retaining international staff, better supporting students, embed new roles and increase apprenticeships

Over the coming months we will again bring together workforce leaders across the system to prioritise and to agree who is best leading various programmes. We have had much success in the past at identifying strengths within our partner organisations and supporting them with resources to lead initiatives across the system and will continue with this approach.



Strategic ambition five:

Leadership and Cultures

Together with our communities and partners we will build kind and inclusive cultures which harness the rich diversity of experience, knowledge, skills, and capabilities from across our system. We will collaborate with others to co-design, integrate and inspire all our people to make a positive contribution in our neighbourhoods, across our places and throughout Frimley.

We will continue to:

- create opportunities for our partners to develop our cultures of compassion and belonging together
- cultivate whole system leadership and partnership working which finds new ways to tackle complex system challenges
- nurture the leadership potential in our people, in every part of our health and care system, equipping them to work across boundaries together with communities to improve outcomes through tackling inequalities
- engage with our communities to deliver improvements in the integration of services for better access, experience and outcomes
- embed the universal Freedom To Speak Up principles, ensuring our people feel empowered, supported and confident to challenge and offer suggestions to improve ways of working.

We will create a thriving environment which values the power and strength of our diversity and ensures our people feel empowered and confident to challenge when things are not right and to offer suggestions to improve ways of working. This will contribute to an inclusive leadership culture which enables equity of access to services, support and opportunities for our communities and staff through life and career.

Leadership and Cultures

Throughout our engagement on this strategy refresh we heard clearly from our partners that the need for developing our collective ability to lead improvement continues to grow. There was a recognition that our priorities and programmes under this ambition need to adaptive and responsive to the changing context in which we work. As such we will continue to ensure we evaluate, reflect and adapt our programmes on an ongoing basis. We also heard some key themes which we will address through our priority areas, these included:

- Ensure our voluntary, community and social enterprise partners, alongside residents and communities can engage and develop their leadership skills so they can make a difference in the communities where they live and work
- Continue to broaden access to our leadership programmes supporting underrepresented partners to take part in our offers (e.g. housing, fire, police etc)
- Work together with our children and young people and relevant partners to offer opportunities to develop our leaders of the future
- • Ensure a mixed offer of programmes and activities that can support more people to benefit (e.g. bite-size programmes, mix of virtual and face to face) and link to the outcomes of our system objectives
- Continue to support those people that have benefited from our leadership offers to make a positive difference in the work that they do on an ongoing basis – growing our 'community of practice'

In addition, we recognise that our culture is the sum of our behaviours, and our leadership behaviours have by far the greatest direct impact on our culture. We will continue embed our 'Frimley Way' through our partnerships and the way that we work together.

Achievements

Our Frimley Academy was established in 2018 and over the past four years we have been through several distinct phases which have shown how we have adapted to the changing environment around us. Phase one saw us respond to the priorities identified through the engagement we undertook on our 2019 strategy 'Creating Healthier Communities'. This strategy highlighted the ongoing need to provide unique opportunities for partners and people to come together, across a wide range of sectors, to develop their system leaderships skills and to tackle the complex change challenges we face. We adapted our flagship system leadership development programme '2020', which was rapidly followed by 'Wavelength' (a leadership programme focused on using digital to drive improvements), alongside several other programmes and offers that equipped our people to lead well in our emerging system context.

Phase two was in response to the Covid-19 pandemic. We rapidly refocused our activities to support our people to deliver and manage well through those extraordinary times. Our refocused offers during the pandemic included 1:1 supportive conversations, bespoke support for teams and sharing of support and wellbeing resources for our people. As we emerged from the pandemic, we undertook a piece of work with a number of leaders from within, and beyond, our system to understand the leadership values that had helped them through one of the most difficult events in the history of the NHS. These values and behaviours are now being embedded across our system and are known as the 'Frimley way'.

We have now entered phase three and we have relaunched the work of our academy. Frimley Academy continue to provide nationally recognised system leadership and learning development programmes, which bring together leaders and professionals from all parts of health and social care, Ministry of Defence, local government, and the voluntary, community and social enterprise sector. We have expanded our system leadership and culture offers which strengthen our collective capability for system partnership working that makes a difference for our communities. This includes over the past year delivering 10 offers, reaching over 650 people and promoting the opportunities provided by our partners across the system.

Leadership and Cultures

Our collaborative network of partners is key to the work we have achieved so far in delivering our culture and leadership ambition. The strength of our partnerships comes from the support and commitment of partners and means that we have been able to increase the spread of our system offers and support – including access to individual coaching support networks, facilitation and team development coaching. The role our Frimley Academy plays as a system convenor and co-design support has meant we have been able to create the space to accelerate system development, foster relationships and enable genuine collaboration for spread and adoption.

In addition to the work of the Academy there has been significant progress made in our system on building our cultures of belonging and inclusion. Over the past year we have co-designed and agreed our five Frimley ICS Equality, Diversity, and Inclusion (EDI) Ambitions and have also held a series of system-wide events to explore our culture of inclusion and belonging, including the Frimley ICS EDI Conference attended by people from across all parts of the system and shared with many more.

"A fantastic way to broaden my horizons on the integrated care system and impact of digital transformation!"

"20/20 is energising, positive, exciting and progressive. Thank you Frimley Academy ..."

"I came away with a much better understanding and appreciation of the system and the people that make it work as a whole."

2018 – 20/20 Cohort One

Launch

2019 – Wavelength Cohort One

Refocus – Using insights in our design

2020 – Focused response to Covid-19

Relaunch

2021 – FRIMLEY 10:100 Cohort One

Refresh

2022 – MARY SEACOLE LOCAL PROGRAMME

Our purpose

Frimley Academy exists to nurture the leadership potential in all of our people in every part of our health and care system, equipping and supporting them to work across boundaries together with our people and communities to improve outcomes by tackling inequalities

We strive to provide inclusive opportunities and the environment which enables all of our people to develop together as system leaders who transcend boundaries

To inspire whole system community leadership networks which harness new ways of working to tackle complex system inequalities

20/20 Cohort Four

Wavelength Cohort Three

Click here to learn more about the work of the Frimley Academy

Bracknell Forest ⬡ North East Hampshire and Farnham ⬡ Royal Borough of Windsor and Maidenhead ⬡ Slough ⬡ Surrey Heath

Leadership and Cultures

Priorities

We will continue to ensure that we create opportunities for communities, people and partners to develop our cultures of compassion and belonging together. We will work to cultivate our whole system leadership and partnership working which finds new ways to tackle our complex system challenges. We will ensure we expand our system leadership and culture offers strengthening our collective capability for advanced system partnership working that makes a difference with our communities. We will also create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities. We will base the way we work around the 'Frimley Way' so that we are building our cultures in the way we do our work together across the system.

We will deliver our system **equality, diversity and inclusion ambitions** – building on our equality diversity and inclusion strategy which is focused on being anti-racist, free of all forms of discrimination, bullying and harassment. We will build more diverse leadership, representative of the diversity of our system. These will be enabled through a range of supporting interventions:

- Frimley ICB mirror board
- Cultural Intelligence
- Reciprocal Mentoring

We will develop our system wide **Freedom to Speak Up strategy and vision** – empowering our people to speak up when things are not right and co-deisgn improvements. Embedding freedom to speak up in our inclusive culture and share learning across the system so we make a positve difference

By leveraging our **leadership networks** – we will accelerate the spread and adoption of system change and maximise the impact of those that have benefited from our leadership and culture interventions through a community of practice

Nurturing a **shared learning culture** will create the space to stimulate radical thinking, meaningful collaboration and bold action to tackle inequalities, harnessing collective intelligence and wisdom of all parts of our system to emerge. We will continue to broaden access to our leadership programmes supporting underrepresented partners to take part in our offers.

Enabling greater **community led capability** development will support and empower the communities we serve, in the places that they live. We will listen to what's important to them and develop our community and partner leadership skills together.

Alliance and coalition building will create a more permissive environment of collaborative networks and adaptive partnerships and link with the systems other ambitions and programmes (e.g. children and young people)

We will expand our **culture and leadership offers** – to reflect our system challenges and build our system leaders of the future and ensure a mixed offer of programmes and activities that can support more people to benefit

95% tell us that having the time and space to reflect on their role, their influence and how to improve and lead realistic change in their organisation is making a big difference in their working lives

100% strongly agreed that the programme enhanced their confidence and skills in connecting and collaborating across boundaries

To watch a short film about Courageous Conversations please click on the icon or scan the QR code

Leadership and Cultures

Benefits and sustainability

Our leadership and cultures ambition brings together key shared leadership and culture priorities, opportunities and challenges drawn upon the collective wisdom, insights and strategies of our partners. The ambition aims to deliver mutual benefits aligned to existing work of our partners, our future system partnership ambitions, as well respond to the recommendations of the recently published review of leadership in health and social care (June 2022).

Cultural competence and inclusion are integral to the future success of our ICS. As a system we recognise that we are all leaders, what distinguishes the culturally competent leader is the profound commitment to understand deeply the people they work with in their teams, our communities we serve, their unique priorities, challenges, and the strengths of each.

We will continue to develop the ambition as we move forward building our collective system capabilities, the learning from of our strong history of system working and our tried and tested leadership behaviours which describe how we work with our partners and the communities we serve. Our aspiration is that by focusing on 'the way we do things' - we will create a thriving system in which our residents and our people can make a positive difference to the lives of those that live and work in Frimley.

Through our actions we will:

- Continue to equip our people with the skills and capabilities to manage change in complex systems and deliver better outcomes in services and ways or working through our 'change challenges'
- Support our people to embed the 'Frimley Way' and develop connected and compassionate leaders
- We will increase the number of people that benefit from our programmes year on year and will develop new offers in new ways to increase the diversity and numbers of people across our system leading improvements
- We will deliver our system wide equality, diversity and inclusion priorities delivering an inclusive culture in which people feel they belong and use measures such as staff surveys and equality monitoring data to demonstrate improvements
- We will develop our system network to share learning from Freedom to Speak Up, demonstrating how we have made a difference through embedding improvements as a result of people speaking up
- We will create our community of practice which leverages the capacity and skills of our people to create positive change
- We will contribute to the opportunities for development for all people across all parts of our system supporting our communities and staff through life and career as demonstrated through measures such as retention and feedback from our communities and staff

Evaluation data on the personal and professional impact of our targeted system leadership development report **100% success** across all participants in the core areas of greater system awareness, enhanced skills and improved relationships and networks for system working across system.

We have nurtured and supported leaders at all levels to initiate over **200 system change challenges** with approximately 90 currently ongoing and 40 completed. Despite system demands we are seeing a marked increase in willingness for system activism.

Leveraging **greater leadership development diversity and inclusion:** Working with our partners we have successfully delivered a **300% increase in access to leadership development** through a combination of increased cohorts and system representative recruitment approach. The overwhelming feedback at place, partner and system level is that this has generated positive leadership and culture momentum that we must maintain and build on as a system. There are clear opportunities to do so.

Strategic ambition six:

Outstanding use of resources

Outstanding use of resources means that the system will collectively aim to deliver the greatest possible value to support the health and wellbeing of the population, with the resources available. Our long term commitment to reducing need and health inequalities will support the long term sustainability of health and care services. We have made digitally-enabled care a priority for this ambition.

We aim to be known for working together to maximise the impact of the skills and capacities of our staff, making decisions based on good intelligence, our digital capabilities, our ‘Frimley pound’, our local buildings and facilities. We will shift resources to maximise benefits.

The ICS will ensure joint prioritisation and effective utilisation of all our resources including financial, estates, digital and workforce, recognising these as our as our key strategic assets.

Although future financial resource flows are unknown, and national strategic workforce planning is a work in progress, it is clear that without transformation the system will be facing a financial gap that will only increase over time. The financial challenge across our partnership is a real "here and now" issue which is already leading to difficult decisions for organisations and elected representatives to have to take around which services can be offered to local people.

The strategy aims to close the resource shortfall by improving people’s health and wellbeing outcomes, thereby reducing the demand for resources in the treatment of poor health.

Outstanding use of resources



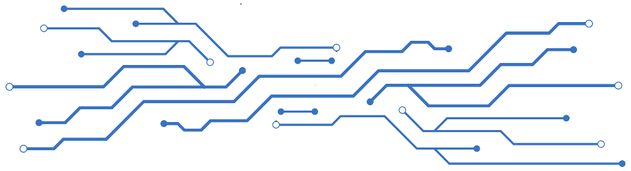
Achievements

The pandemic has influenced the delivery of this, as every other aspect of system strategy since 2019.

However, there is much learning to be taken from the world-changing events since then. The pandemic has been a catalyst for significant innovation and driven more collaborative working in areas that otherwise might have been the case.

New opportunities have arisen in areas such as digital wellbeing and connectivity, population health management, remote monitoring of health and wellbeing and remote working which has the potential dramatically to reduce resource consumption in non-clinical estate.

The ambition aims to seize the opportunities presented and to harness the new learning in pursuit of the system's key strategic ambitions.



We will future proof our system by having a **leading digital and analytics ecosystem** which will deliver practical improvement through **transformation** and cultural change using digital innovation.

We will develop a digital offer for patients, residents, staff and system that supports the delivery of all of our strategic ambitions. It will give us **greater insight** from our data to make informed decisions and target our improvement actions. It will give people the information they need to **prevent ill health** and manage their own health. It will **support automation** and more productive ways of working.


Digital

Since 2019, we have delivered some key achievements within Digital and Analytics

- Developed a nationally leading population health intelligence platform
- Established population health analytics support that is now embedded in decision making across the ICS at system, place and PCN level
- Developed digital enablers that improve access for residents to Primary Care
- Embedded evidence led improvement and transformation using population health management approaches
- Nationally leading use of remote monitoring
- First area in the UK to implement John's Hopkins' patient segmentation approaches
- 65k accesses from 5k unique users of the shared care record every month
- Use of population health management to improve diabetes and hypertension management and outcomes that has measurably reduced variation in deprived communities as well as driving support for residents hardest hit by the cost of living crisis
- Use of population analysis to target communication activity and spend to key cohorts
- Establishing close collaboration between clinical leadership, digital, transformation and analytics to drive change
- Increase the flexibility of our estate by maximising digital ways of working

Estates

Our estate is a key driver for transformational change. The system will invest in upgrading facilities in an aligned way across health and care, making best use of public money to provide flexible facilities close to where people need them. We want to enable our staff to work in the most efficient way by utilising the estate and digital capability to maximum impact.

We will focus on delivering a number of key estates programmes across our system including cross-sector initiatives and in developing and embedding a system evaluation and planning cycle for capital investments. Over the period of the strategy our achievements to date include:

- Heatherwood Hospital redevelopment and renewal.
- Investment in GP estate.
- Integrated Care Hub in Farnborough in partnership with Rushmoor Borough Council.
- Community hospital reconfiguration.
- Cross-sector partnership developments, including Heathlands in Bracknell.

Outstanding use of resources

Priorities

The system will work collaboratively to a **single system resource** envelope across the health and care system in support of clinical and operational strategies to deliver the key strategic ambitions.

We will work to enable more **fully informed decision making** in the use of the resources available to deliver the greatest possible value for the health and wellbeing of the population.

We seek to predict future demand under a “do-nothing” scenario and to develop our ability to:

- **reduce the need for costlier healthcare interventions** through investment in preventative and wellbeing interventions
- **utilise digital innovation** to deliver greater value for our population
- **optimise capacity** to meet demand and better mitigate demand that could be addressed more effectively elsewhere

The targeting of health inequalities is a key action for the delivery of a **sustainable service model** which provides the greatest possible value. It is well-evidenced that deprivation drives health inequalities which in turn drive greater utilisation of resource-intensive treatment. A focus on the improvement of health and wellbeing outcomes in our most deprived neighbourhoods will therefore have the greatest impact on consumption of resource in the treatment of poor health, which will free resource for reapplication in further preventative and wellbeing developments.

The development of planning and delivery **relationships with the voluntary sector, charitable organisations including hospices and commercial sector providers** has the potential to enable the application of a far greater level of resource than statutory organisations are able to bring to bear in the delivery of best value for our population’s health and wellbeing. This must therefore be a priority as we work to deliver this objective.

In light of the finite nature of our resource, the system should have a **conversation with the public** which seeks to articulate the limitations of our financial and workforce capacity in order that a more fully informed public is able to help us to prioritise our resource application.

Finally, our physical estates continue to experience signficant challenge with the need for urgent capital investment clearly visible. The most pressing example of this is the use of RAAC plank building materials across the Frimley Park Hospital site, reducing the ability to use the full estate for patient services. A priority for this period will include securing additional investment to address this challenge.

Digital, analytics and transformation priorities

- Further developing the breadth, capability and use of our Shared Care Record
- Continue to expand the nationally leading use of remote monitoring as a prevention opportunity
- Improving the seamless flow of data between organisations across the health and care system
- Improving data quality, timeliness and breadth of data being shared
- Improving digital literacy and the use of insights to drive evidence based decision making
- Embedding a system wide analytics operating model that optimimises the use of analytics resources and focuses on driving meaningful outcomes
- Scaling nationally leading, locally developed, population health intelligence tools to support other systems across the UK
- Increasing the use of evaluation to support decision making and rapid improvement cycles
- Moving from descriptive analytics to greater emphasis on predictive and prescriptive techniques and data science
- Greater focus on patient reported outcomes and better understanding the voice of our residents
- Greater insight supporting evidence based decision making at system, place and neighbourhood levels. Incorporating wider determinants and resident provided information to drive population health management and system intelligence.
- Support a move towards self-care and prevention by integrating the good work in health and social care with app and resident-facing technology integration.
- Use digital tools and evaluation of our interventions to underpin work to reduce inequalities for residents across the system.
- Increase the flexibility of our estate by maximising digital ways of working
- Stronger integration with children’s social care and education to support targeted and coordinated wellbeing offer to children to start well.

Benefits and sustainability

The optimal use of resources will support the whole system in achieving its vision of improving the lives of our residents and addressing health inequalities. The use of digital technology will empower our workforce to work differently, creating capacity as well as improving quality outcomes for residents. Improving access and the use of technology will also support patients to better navigate the health and care system and empower patients to take greater ownership of their health and wellbeing.

The ambition directly addresses this issue, to drive a service which maximises health and wellbeing outcomes, minimises health inequalities and demonstrably delivers the greatest possible value for the resource entrusted to us on behalf of our population.

Our next steps together

Our Shared Commitment to Delivering Progress

This refreshed ICS Strategy is the first step in the next phase of our joint work together as partner organisations. We are committed to continuing our efforts to deliver improvements against our two Strategic Priorities, **Reducing Health Inequalities** and **Improving Healthy Life Expectancy**. This document sets out where we think the greatest opportunities lie ahead of us in making this a reality for our residents.

Our intention is to work with residents, staff, elected representatives and organisations in Q4 of 2022/23 to share this draft strategy and **hear further feedback** as to how it can be strengthened. We will seek to update the strategy to reflect as much of this feedback as possible, prior to the Integrated Care Partnership being asked to endorse this strategy at its meeting in March 2023.

As we enter 2022/23, we will seek to **work with partners** in their organisations and **Health & Wellbeing Boards** to ensure that we have credible plans for delivering improvement against these strategic ambitions as set out in this document. We have already signalled an intention to bring greater clarity to the expected benefits of this work for residents and staff, backed up by a clear understanding of the metrics and indicators which will tell us whether our shared work in this area is delivering tangible progress.

Delivering on the improvement opportunities identified in this strategy is a **collective responsibility**. We have highlighted these areas of focus because they are deliverable only with ambitious involvement from the organisations which make up our partnership. By **working together** in line with our **shared values**, we will hold each other to account for the delivery of our strategic purpose in the right way.

Over the past three years we have invested significant time in building new delivery capability, creating new vehicles for transformation which are not rooted in the traditional organisational architecture of the twentieth century. We will make the most of our ICP, ICB, Health & Wellbeing Boards and Provider Collaboratives to **achieve our goals** because we know that these partnership constucts will give us the best chance of success.

Addressing the wider determinants of health and wellbeing

Our greatest opportunities for achieving success together will come through addressing the broader factors which determine the health and wellbeing of our population.

In the months ahead we will embark on an ambitious agenda-setting approach to making best use of our Integrated Care Partnership to create the time and attention required to delivering shared improvement in these areas. Focus areas which have already been suggested by our partners for subject matter workshops include:

- **Social and Private Housing, Planning and Development**
- **Healthier Spaces, Leisure and Tourism**
- **Economic Development, Skills Development and Training**
- **Understanding the Social Care provider sector and exploring quality improvement opportunities**
- **Making best use of our collective Public Sector physical assets and anchor institutions**
- **Digital provision of health and care support to workforce, patients and residents**
- **Securing long term sustainability, including environmental improvement opportunities and the broader Green agenda**

Delivering improvement from this strategy and therefore improvement for our residents is contingent on identifying the opportunities for change which are present in all of the above. As the ICP continues to evolve and develop, it will provide a critical forum to secure this.

Staying in touch

Insight & Involvement Portal

We have created a page on our Insight and Involvement Portal that will be updated with progress on the development on the refreshed strategy. Please take the time to visit to share your views and to see the partnership work undertaken to develop the Strategy to date.

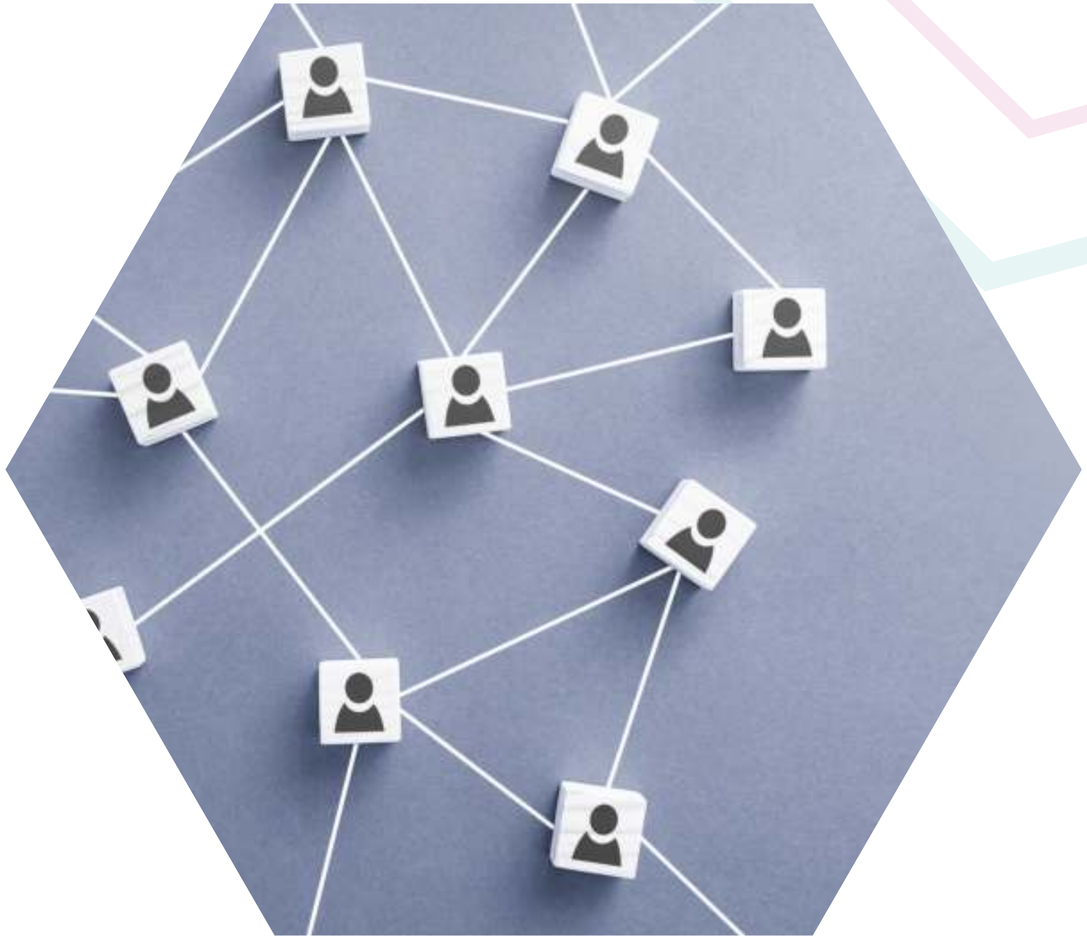
insight.frimleyhealthandcare.org.uk/strategyrefresh

You can also visit our system website for a wide range of information about Frimley Health and Care, how to get involved in our work and up to date health and care information and resources that can be shared with friends, family and colleagues.

www.frimleyhealthandcare.org.uk

Take a moment to check out our social media channels. Please follow and share to stay up to date with a wide range of health and care information.

If you are reading a printed copy and wish to access any of the digital content or if you require information in other formats, please email: **frimleyicb.public@nhs.net**



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Health and Wellbeing Board (HWB) Paper

1. Reference information

Paper tracking information	
Title:	Health and Well-being Strategy Index
HWBS Priority Populations:	All Priority Populations
Priority - 1, 2 and/or 3:	• Priority 1 - Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being • Priority 2 - Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being • Priority 3 - Supporting people to reach their potential by addressing the wider determinants of health
Principles for Working with Communities:	Community capacity building: 'Building trust and relationships'
Interventions for reducing health inequalities:	Civic / System Level interventions
Outcome(s)/System Capability:	Data, Insights and Evidence
Author(s):	• Uma Datta, Assistant Director, Data and Insights, Public Service Reform, (SCC); uma.datta@surreycc.gov.uk • Phillip Austen-Reed, Principal Lead – Health and Wellbeing (SCC); phillip.austenreed@surreycc.gov.uk
Board Sponsor(s):	Ruth Hutchinson, Director of Public Health (SCC)
HWB meeting date:	15 March 2023
Related HWB papers:	September HWBS Metrics paper
Annexes/Appendices:	N/A

2. Executive summary

At the September Board we discussed an approach to the development of metrics that would enable an understanding of how effectively we are delivering the Health and Well-Being (HWB) Strategy. In this update, we discuss how we have taken this approach forward and developed a visual means for Board members, partners and Surrey residents to view how the metrics are contributing to the key priorities.

We have used the previously identified relevant metrics/measures and mapped them to each to one of the three Priorities. As previously highlighted these also cover as many of the Priority Populations as currently possible. The combination of the metrics (with relevant weighting) then produces a Priority sub-index. The three Priorities are then combined to provide a Health and Well-Being Strategy Index.

The HWB Strategy Index is constructed using a methodology similar to the Surrey Index and will be presented as an interactive dashboard at the March Board meeting. It will then be available publicly via Surrey-i.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Review, provide feedback and promote awareness of the metrics within their organisation to enable a common understanding and assessment of progress.

4. Reason for Recommendations

The new Health and Well Being Strategy Index is the first of its kind that's been developed for Surrey and for the HWB Strategy. It is intended to allow us to view the progress of the Strategy through certain key indicators where data is available and which enable an understanding of the effectiveness of the Strategy and its delivery.

It needs to address the requirements of all local partners as far as possible as well as providing a clear understanding to our residents of how we are delivering the Strategy. In building this, we have used certain assumptions but it is intended to be iterated and improved over time as more information and data becomes available. It is for this reason that regular feedback from all partners will be particularly beneficial, and hence we are recommending spreading awareness of the Index to encourage feedback.

5. Detail: The Health and Wellbeing Strategy Index

As previously mentioned, through placing the HWB Strategy Index within the Surrey Index, the intention is that it can be used as the common reference point for shared health inequality related indicators for all partners. These are often included and referenced in individual organisational strategies, however with no single organisation being able to significantly impact individually, this will ensure a common system wide focus on these indicators. The proposed alignment of these various elements is represented below in figure 1.

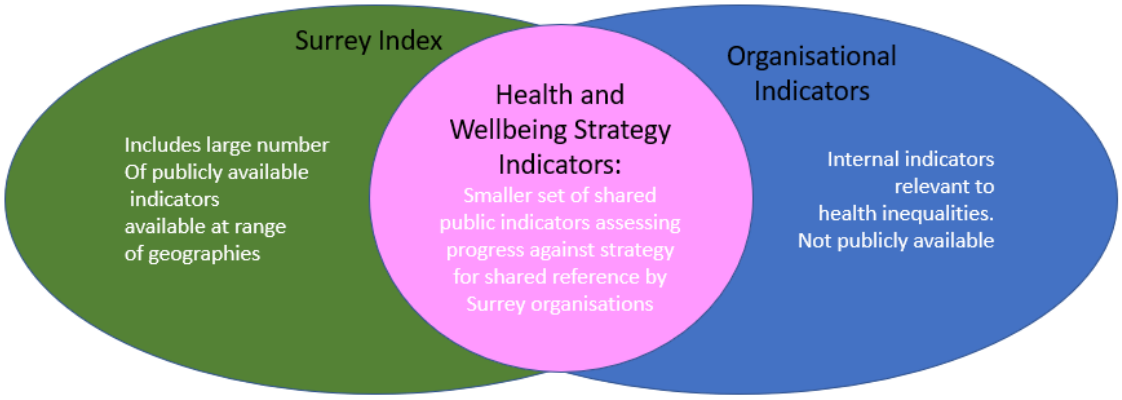
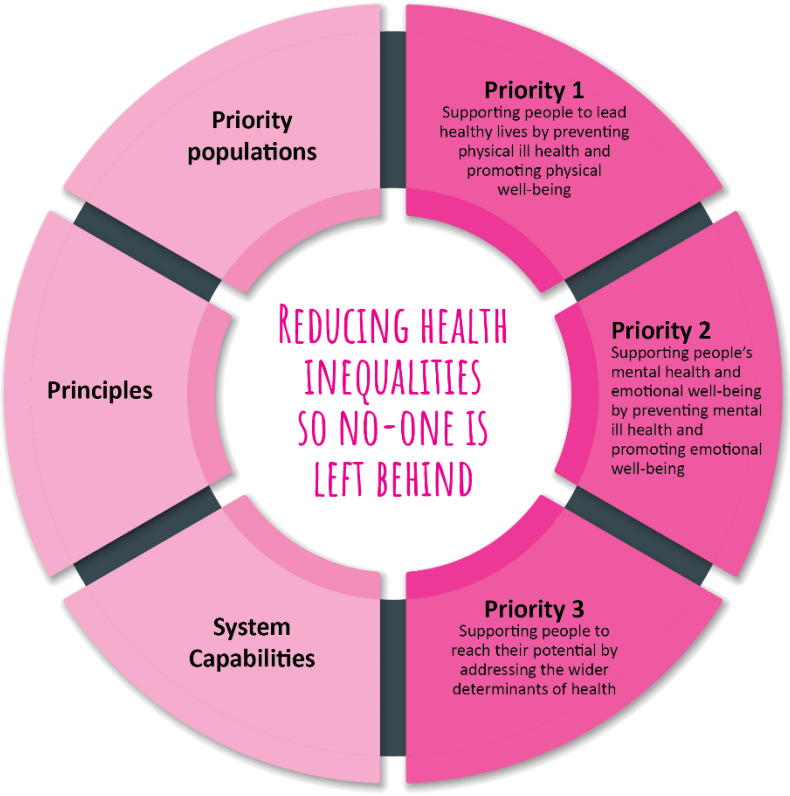


Figure 1: Health and Wellbeing Strategy Index is located within the Surrey Index using public indicators that can be referenced by partners alongside internal organisational indicators to understand progress being made against the strategy priorities and reducing health inequalities.

It is intended that this will aid the movement towards a greater system wide understanding of reducing health inequalities that will complement the work of partner organisations and how they are collectively contributing to reducing health inequalities.

The new Index utilising the Surrey Index format has been constructed with the various metrics to assess the impact and efficacy of the refreshed HWB Strategy. This is presented in a dashboard format which replicates that used in the Surrey Index (available at: https://www.surreyi.gov.uk/surrey-index/).

The measures have been allocated to one of the three HWB Strategy's Priorities outlined in the following diagram, and to one of the identified outcomes under those priorities.



There are varying numbers of metrics identified under each Priority and under each Outcome, and so we will combine all contributing metrics (where there is reliable data) to form an 'overall' Priority score, and an 'overall' Outcome score, using methodologies applied to same effect in the Surrey Index. If there is no reliable data on some metrics, the overall score can only be measured by what's available. It should also be noted that the indicator referenced under one priority or outcome may also contribute to others and to single or multiple priority populations, so weightings will need to be applied.

Initially, individual metrics are likely to be attributed equal weights when combining, although as the Index develops it will be adjusted to take account of clear and obvious differences in range and reach of each metric. For example, a whole population count will eventually be accorded greater statistical weight than a survey-derived metric value.

There will therefore be a single **"Result"** score for each of the three priorities, and each of the 14 outcomes, as well as for each metric individually.

5.1 Approach and methodology:

- The measures selected encompass a range of data collections, some of which are open source and publicly available.
- Reporting periods, frequency of refresh, data collection methodology, system coverage, and lowest level of geographical reporting vary widely.
- To date we have focussed on defining specific measurable indicators that best match the HWB Strategy, identifying accurate and reliable data sources, and accessing and securing time-series data values.
- Wherever possible, we intend to disaggregate a Surrey-wide value into lower geographies (districts and boroughs, wards, LSOAs) so that local, area-specific inequalities in outcomes can be clearly investigated and identified, to enable further targeted interventions. This is not possible for every metric however, due to the geographic level at which they are collected and released (see 5.4 below for more details).

5.2 Change over time

We will be using the Index to monitor changes over time and the direction of changes.

The baselines established before the HWB Strategy came into being will set the initial starting context.

The refreshed values relating to performance during the lifetime of the HWB Strategy will serve to quantify our effectiveness at maintaining or improving on those baselines.

For each metric, a "direction of travel" will clearly show whether we are improving or not against the last assessment, as well as whether we are improving or not against improvements seen elsewhere. Direction of travel will therefore have both an **absolute** and a ***relative*** improvement component.

5.3 What "Good" looks like

In order to understand how we are progressing with the HWB Strategy it is important that we develop an indication of what good looks like and this will need to reflect the over arching ambition of reducing health inequalities. No target values have been set for the metrics thus far however and so we will be determining "what good looks like" going forwards against two initial comparator positions:

(a) the England average, and

(b) the current 'best' result available for a county area level.

Surrey values that are 'better' than the England average position to a significant degree will be deemed "Green"; those that do not differ significantly from the England average position will be deemed "Amber"; and those deemed to be

significantly worse than the England average position will be deemed "Red". In this way we will derive a traffic light status for the last known Surrey position for each measure. Where the data permits a comparison between the different geographic parts of Surrey, the same methodology will be used to measure inequality between the different parts.

5.4 Frequency of reporting

For metrics that are refreshed more frequently than once a year, we will initially only report to the Board an annualised average position, or opt for one data point as a reflective coordinate for the year in question if data is an accumulated count annually. For example, we could choose to report the position as at the end of March (for a year on year comparison) even if monthly refreshes could mean we can report for other months. As the Index develops, we hope to make automated updates as and when data values change, such that the latest established position is always reflected as such; this ambition will however take time to embed.

If there is any significant change for the worse in a particular indicator within the year, this will be highlighted against the relevant priority through the quarterly HWB Board Highlight Report.

For metrics that are refreshed *less* frequently than once a year, we may find that the initial baseline only is available, and no refreshed data points coinciding with the activity of the HWB Strategy will be possible until such time as fresh data is released.

5.5 Different geographic levels

Where it is feasible to establish lower-geography positions, these will then be rated on the basis of their contribution to (and deviation from) the Surrey-wide value – i.e. to highlight areas of under- and over-performance compared to Surrey as a whole and support alignment with the HWB Strategy's mission – to reduce health inequalities – in a broadly affluent county with hidden pockets of deprivation

As with the Surrey Index, we intend to make map views available at all levels of geography that data variables can be disaggregated to:

Typically, these will include:

- Smaller geographies including middle layer super output areas ('MSOAs'), lower layer super output areas ('LSOAs'), and output areas ('OAs')
- Primary Care Networks
- Electoral divisions and electoral wards
- District and borough councils
- County

This functionality will enable area-specific health outcomes and variations within these to be readily identified and acted upon by the relevant authorities and their partners.

5.6 Overall view of how well we're doing on achieving the HWB Strategy ambition

In addition to metrics contributing to the individual priorities, four measures have been chosen as indicators of the overall success of the HWB Strategy to reduce health inequalities:

- Gap in life expectancy and healthy life expectancy for females between the parts of Surrey experiencing the longest and shortest average life expectancies (to reduce)
- Gap in life expectancy and healthy life expectancy for males between the parts of Surrey experiencing the longest and shortest average life expectancies (to reduce)

Since life expectancy statistics are both slow to change, and infrequently aggregated, these are unlikely to be observed to improve within a short time period. Therefore, we intend to create simple to read summaries of 'overall' improvement based on the more regularly reported metrics of the set, to help gauge system-wide success (or otherwise) and help direct appropriate support to interventions related to the outcomes, priorities and priority populations in the HWB Strategy where improvement is required.

The Index will be **published on the Surrey-i** public information site, available for reference to all members of the HWB partnership and to our residents too.

6. Challenges and opportunities

- Some indicators relevant to assessing progress of the Strategy's priorities continue to only be available at a higher Surrey footprint which limits the benefit of use at a local system level.
- The new approach to align with the Surrey Index does mean that where more local data is available this will be more obviously accessible which supports the Surrey Data Strategy and work to align dashboards and processes within the health inequalities landscape.

7. Next steps

- As the Surrey Data Strategy gathers further momentum these indicators will continue to be reviewed and developed to ensure we are utilising the most appropriate indicators to monitor our progress against our overall ambition, priorities, outcomes and the needs of our priority populations.

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Health and Wellbeing Board (HWB) Paper

1. Reference Information

Paper tracking information	
Title:	Wider Determinants of Health: Surrey Skills Plan
HWBS Priority populations:	All of working age that can work
Priority - 1, 2 and/or 3:	• Priority 3 Supporting people to reach their potential by addressing the wider determinants of health
Outcomes/System Capabilities:	▪ People access training and employment opportunities within a sustainable economy
Principles for Working with Communities:	• Community capacity building: 'Building trust and relationships' • Co-designing: 'Deciding together' • Co-producing: 'Delivering together' • Community-led action: 'Communities leading, with support when they need it'
Interventions for reducing health inequalities:	• Civic / System Level interventions • Service Based interventions • Community Led interventions
Author(s):	Jack Kennedy, Head of Economy and Growth, Surrey County Council; jack.kennedy@surreycc.gov.uk, 07790 773496
Board Sponsor(s):	Mari Roberts-Wood, Managing Director, Reigate and Banstead Borough Council (Priority 3 Sponsor)
HWB meeting date:	15 March 2023
Related HWB papers:	N/A
Annexes/Appendices:	• Annex 1 - 'Wider Determinants of Health: Surrey Skills Plan' presentation

2. Executive summary

The Surrey Skills Plan (SSP) was launched in November 2022. The plan forms the strategic basis for delivering skills priorities in Surrey and sets out a collective vision for a dynamic, demand led skills system.

The SSP has four strategic objectives, with the second objective 'Supporting People' aligning most closely with Priority 3 of the Health and Wellbeing Strategy.

The attached presentation provides an overview of the SSP, an update on the implementation of the Supporting People objective and asks the Board to consider how it can support the delivery of the SSP ambitions going forward.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Note progress against the implementation of the Surrey Skills Plan.

2. Consider how HWB members and organisations can engage with delivering the Surrey Skills Plan ambitions.

4. Reason for Recommendations

The SSP sets out the challenges and opportunities facing the Surrey economy in terms of recruitment and skills. Due to the combination of factors impacting the Surrey labour market which have seen substantial increases in demand for people and skills against a decreasing level of supply, action is required by both Surrey County Council and a wide range of partners, including members of the Health and Wellbeing Board, businesses and training providers, to positively impact this agenda. Through doing so, we can help to support economic growth and provide greater opportunities for Surrey's residents, supporting the principle of leaving no one behind (NOLB).

It is essential the ambitions of the SSP are delivered in partnership with all stakeholders in the skills system, and to this end Board members and their organisations are asked to consider how they can support the delivery of the SSP ambitions going forward.

The development phase of the SSP was presented to the HWB in July 2022. This report and the attached presentation (Annex 1) provide the HWB with an overview of the SSP, an update on the implementation of the Supporting People objective and sets out a number of asks for the Board to discuss concerning supporting the delivery of the SSP.

5. Detail

Overall, the UK's skills system is complex and largely fragmented and Surrey is no exception to this. Activity generally takes place on an institution-by-institution basis; whilst colleges, universities and businesses connect with each other, prior to the launch of the SSP there has been no coherent Surrey-wide perspective on what good practice is being delivered and where opportunities to operate at scale and make improvements might be implemented.

In Surrey we are fortunate to have several effective and well-respected training providers including our schools and sixth form colleges, further education colleges, universities and independent training providers. However, we also hear regular feedback from businesses, both large and small, that the current skills system is

difficult to engage with and is not always flexible enough to respond to modern day business demands.

Not only do employers find it hard to navigate the system but people who face barriers to employment equally find that it is hard to both enter and progress through the system which is primarily set up for a linear academic pathway into a recognised career. Through the work being led on 'No One Left behind' in SCC the SSP recognises the importance of ensuring opportunities are available to all.

We know there is a clear, established link between improved employment outcomes and improved health outcomes. Therefore, the 'Supporting People' is closely linked to Priority 3 *(Supporting people to reach their potential by addressing the wider determinants of health)*

SSP Objective 2 Supporting People: Support inclusive access for Surrey's residents to improved careers education, information and guidance, linked to clear learning, work and training pathways.

- *Help people move between jobs to develop their career locally*
- *Promote access to good quality jobs across foundation sectors*
- *Enable access to opportunities for work progression*
- *Ensure those traditionally excluded from sharing in Surrey's economic success are given the targeted support to enable them to do so*
- *Tackle cold spots in support, education and training provision*

It is important to note the importance of shared ambition and added value from joint delivery that is central to the intent of both the Health and Wellbeing Strategy and the SSP. The SSP itself is not a representation of all existing activity that is currently supporting skills development in Surrey but is instead a recognition of where combined approaches can deliver new and improved outcomes. It requires each stakeholder to build from individual operational drivers towards mutually beneficial complementary action as part of a coherent strategic plan. This, in turn will not only deliver singular benefits to each organisation but will also secure enhanced, multiple outcomes across Surrey.

The attached presentation sets out the focus of the SSP and the activity that is already underway under the *Supporting People* priority.

6. Challenges

- **Partnership and collaboration -** Actions in the Surrey Skills Plan must be delivered through system-wide collaboration, using a range of mechanisms. Taken together, these mechanisms offer meaningful ways to create change in our skills system and interface with the broader policy context for Surrey. There is therefore a risk of partners acting in isolation or not effectively collaborating to deliver system change.

- **Economic factors -** Although unemployment is back down to 2.1%, after rising during the pandemic, and well below the South East (2.9%) and UK (3.7%) averages, there has been an increase in economic inactivity, driven in part by an

increase in those who are long-term sick and those who have retired from the workplace.

7. Timescale and delivery plan

The SSP sets out actions to take within the next twelve months and the next three years that will drive real change in Surrey's skills system, including as part of the Surrey and Mid/North Hampshire Local Skills Improvement Plan (LSIP).

7

8. Next steps

- Continued delivery of the Surrey Skills Plan ambitions.
- Development of the 'Pathways to Employment' business case and funding model.
- Build on key findings from NOLB research, sector skills approaches and pilot projects in neighbourhoods.

Annex 1

SURREY HEALTH AND WELLBEING STRATEGY

Health and Wellbeing Board – Formal (public)

Wider Determinants of Health: Surrey Skills Plan

Page 95

Michael Coughlin

15 March 2023

DELIVERING THE COMMUNITY VISION FOR SURREY

Summary of Presentation

1. Alignment with the Health and Wellbeing Strategy
2. Recommendations
3. The skills landscape
4. Surrey Skills Plan
5. Discussion questions and asks
6. Next steps
7. Challenges / risks

Alignment with the Health and Wellbeing Strategy

- **Health and Wellbeing Strategy**: Priority 3 - Supporting people to reach their potential by addressing the wider determinants of health Including: People access training and employment opportunities within a sustainable economy

- **Surrey's Economic Future:** Priority 3 - Maximising opportunities within a balanced economy

- **SCC's Corporate Priority:** Growing a sustainable economy where everyone can benefit

Recommendation(s)

- The Board is asked to note progress against the implementation of the Surrey Skills Plan

- The Board is asked to consider how HWB members and organisations can engage with delivering the Surrey Skills Plan ambitions

The Skills landscape

Government's Local Skills Improvement Plans (as set out in Skills White paper)

LEPs x 2 - EM3 geography plus four C2C Districts

LSIP led by Surrey Chambers of Commerce

Surrey Skills Plan established as standalone chapter that can be incorporated into LSIP

Led by Surrey Skills Leadership Forum with all key partners

Key recommendations and a series of specific actions / asks to be progressed by the One Surrey Growth Board and Surrey Skills Leadership Forum

Demand for Skills

Research compiled on business needs. Includes current and projected needs in key sectors.

Large and small businesses, skills needs at all levels

Skills Provision review

Provision study completed to help establish how well Surrey is set up to meet the identified need.

Schools, colleges, universities, independent training providers

Workforce Supply

No One Left Behind employment and skills research (SCC)

Establishing the provision targeted at priority communities of need (as defined by HWB Strategy)

Resources to deliver

Wider partner resources to support

NHS, LEPs, SCC,

Ds & Bs, Government

SCC led provision

e.g. NOLB, Adult Learning Service, Multiply, Infrastructure and Health & Social Care Academy approaches

Surrey Skills Plan - Overview

SURREY HEALTH AND WELLBEING STRATEGY

The Surrey Skills Plan (SSP) forms the strategic basis for delivering skills priorities in Surrey. This is a plan for all of Surrey's businesses, skills providers and people.

Our vision is for **a dynamic, demand-led skills system which hones Surrey's leading edge, recognises the needs of all businesses and maximises inclusion, whilst powering economic growth across the UK.**

	OBJECTIVES	
1	**Supporting Business**	**Help businesses prosper by making our skills system more responsive – both to immediate needs and those presented in the medium-longer term.**
2	**Supporting People**	**Support inclusive access for Surrey's residents to improved careers education, information and guidance, linked to clear learning, work and training pathways.**
3	**Enabling Collaboration**	**Deliver a step change in our skills system through enhanced and purposeful collaboration between and across businesses, anchor institutions and skills providers.**
4	**Future Proofing**	**As part of a thematic focus on skills of the future, strengthen the pipeline of priority skills to meet employer demand, recognising the needs of both SMEs and larger businesses.**

DELIVERING THE COMMUNITY VISION FOR SURREY

Surrey Skills Plan - Supporting People

Where we are now	Priorities	Skills Plan Objective	Actions (now/within one year)	Actions (within three years)
Not all our people share in the County's overall success. We have acute pockets of education deprivation, large differences in workplace and resident earnings, and residents who struggle to access employment. Our high cost of living and wider place challenges create further barriers.	• Help people move between jobs to develop their career locally • Promote access to good quality jobs across foundation sectors • Enable access to opportunities for work progression • • Ensure those traditionally excluded from sharing in Surrey's economic success are given the targeted support to enable them to do so • Tackle cold spots in support, education and training provision	**Supporting People:** **Support inclusive access for Surrey's residents to improved careers education, information and guidance, linked to clear learning, work and training pathways.**	**• No One Left Behind research to undertake in-depth discovery of those left behind in Surrey** **• Skills and Employment Network to bring together the region's employment support providers in a more effective network** **• Develop a Surrey County Council skills action plan, recognising the county's role as a leader, employer, procurer and provider** • Establish annual Skills & Careers Festival • Pilot a collaborative approach to careers advice, focused on maximising inclusion • Produce baseline evaluation of current employment support and impact assessment	• Promote work placements and establish a local forum for offering and finding work placement opportunities • Promote technical routes, T-Levels and apprenticeships at all levels across all sectors as alternative pathways into employment ♦ • Develop an employer led, sustainable model of vocational pathways. careers advice and guidance ♦ • Put in place career pathways to professional level for all key occupational routes in Surrey ♦

Key Bold text = already underway ◊ = likely LSIP alignment

Surrey Skills Plan – Example of current activities

Supporting People

No One Left Behind
- Skills & employment discovery – Revealing Reality
- Naturally Talented Me

Pathways to Employment
- Collaborative approach to careers advice
- Targeted support to maximise inclusion
- Festival of Skills

Sector Skills
- Green career pathways
- Teacher encounters
- Digital/cyber careers research
- Animal & Plant Health Agency model

Social Value
- SCC supply chain delivering greater social value outcomes
- Carrington School Day in April to inspire students into public sector careers

DWP Partnership
- Old Dean deep dive leading to employment support provision
- ESOL provision
- DWP staff as 'Numeracy Champions'

Basic Skills
- Multiply - increasing adult numeracy levels
- Year 1 delivery plan commenced in Jan 2023, Year 2 investment plan submitted to DfE

Neighbourhoods
- Frimley Health NHS Foundation Trust to support Old Dean
- Horley jobs fair

Discussion Questions and Asks of the HWB

How can the HWB members and their organisations:

- Help meet current and future skills needs in health and social care through local provision?
- Support delivery of better, earlier career guidance for young people, including alternative career pathways?
- Support inclusive employment across Surrey's economy through social value opportunities in your own organisations and with your supply chain?
- Help deliver better adult careers guidance to improve workforce retention, particularly post-retirement

Next steps

- Continued delivery of the Surrey Skills Plan ambitions
- Development of the 'Pathways to Employment' business case and funding model
- Continue with ambitions around securing County Deal to access greater devolution on skills and employability
- Build on key findings from NOLB research, sector skills approaches and pilot projects in neighbourhoods

Challenges/Risks

- Partnership and collaboration – actions in the Surrey Skills Plan must be delivered through system-wide collaboration, using a range of mechanisms. Taken together, these mechanisms offer meaningful ways to create change in our skills system and interface with the broader policy context for Surrey. There is a risk of partners acting in isolation or not effectively collaborating to deliver system change

- Growing economic inactivity - although unemployment is back down to 2.1%, after rising during the pandemic, and well below the South East (2.9%) and UK (3.7%) averages, there has been an increase in economic inactivity, driven in part by an increase in those who are long-term sick and those who have retired from the workplace

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Update to Surrey Health and Wellbeing Board from Surrey Heartlands Integrated Care System - 15 March 2023

Surrey Heartlands Integrated Care Partnership (ICP)

Agenda items and brief summary from the latest meeting (February):

Population Health Summit

- This paper provided an update on the ICS Population Health Management programme and plans to hold a Population Health Summit on 21 March 2023 at Epsom Downs.
- The Population Health Management Programme lead outlined the aims and the approach of the programme and plans to refresh the roadmap.
- Members were asked if they understood the approach, to identify any gaps in capabilities and their views on plans for the Population Health Management summit.

Delivering In Partnership: Towns

- This report revisits a previous paper which set out an approach to building local partnership delivery arrangements around towns.
- In the report, towns were defined as distinct, recognisable places and communities around which partners could coalesce and work together.
- Moreover, it updated on the proposed extension of the partnership delivery programme, as well as the next 10 towns for which the approach will be developed, assuming operational issues are resolved.

Hewitt Review

The Chair gave an update on the Hewitt review, and its timelines with the report to be published shortly in March. The Chair shared slides which outlined the 7 recommendations of the Integration and Place workstream to be published.

Forward plan items

The March Formal meeting will discuss the following topics in more depth:

- **Integrated Care Partnership Plan Approach**: Brief update on an outline of suggested approach towards how we envision the Integrated Care Partnership will run. This involves structuring the meeting using the Hewitt Review Recommendations, and our Key Neighbourhoods and Priority Population Groups.
- **Hewitt Review:** Final update on published review and ICP to consider how it can implement recommendations of the review.
- **Serious Violence Duty** To give an overview to ICP members on the Serious Violence Duty, the operational group and how member can engage.

Surrey Heartlands Integrated Care Board (ICB)

- A video regarding anticipatory care hubs in East Surrey was shared. This featured feedback from patients on how this had transformed their care. This was followed by a more detailed account of how PCNs and provider organisations had worked together since transformation funding had been provided in 2019 and a patient story setting out how the approach could transform individual care.

- System demand and capacity plus industrial action meant that there were significant issues with delivering services, which staff had worked really hard on.

8

- The governance arrangements for East Surrey were set out and in particular how these were supported by developments in data and mapping across to other themes such as the critical five and Fuller Stocktake (refer to Annex 1 - 'One System, One Plan' Presentation and the link to the 'One System Plan': https://www.surreyheartlands.org/one-system-plan).

- The progress on the Joint Forward Plan and 2023-24 Operational Planning were noted – these would be signed off at subsequent meetings.

- The Surrey Heartlands Green Plan was AGREED.

- Regular reports on finance and quality were received, showing significant pressures and challenges across the system.

One System, One Plan

Prof Claire Fuller - CEO

Dr Pramit Patel - Partner Member for Primary Care Services

One System, One Plan

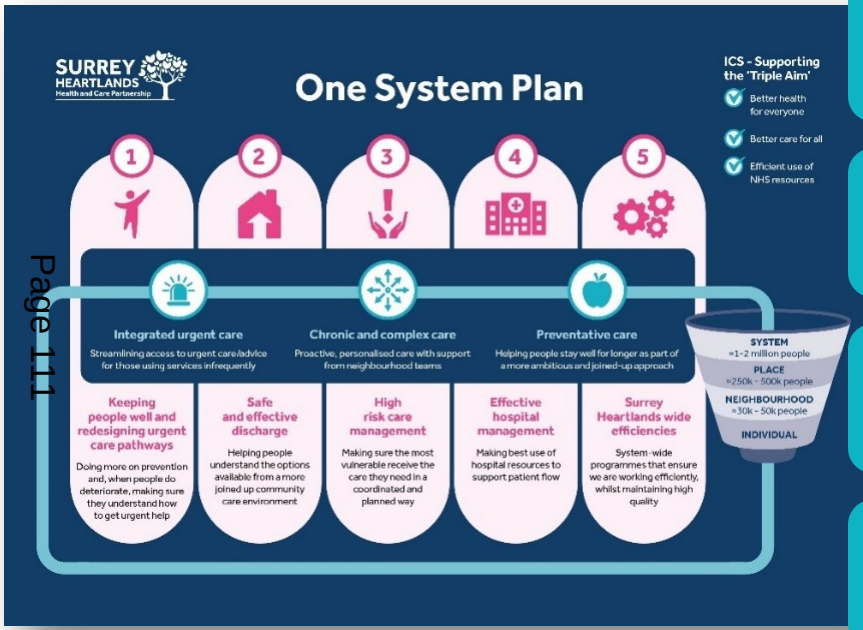
The purpose of this document is to support health and care leaders and teams right across Surrey Heartlands to understand and embrace the opportunities our new way of working presents.

It sets out how we are creating the conditions to break down many of the organisational barriers that have previously got in the way of health and care organisations delivering their services optimally to best meet the needs of our patients.

At the heart of the document is how we are aligning everything we do in health and care to achieve two keys aims:

- **Making it easier for patients to access the care that they need when they need it, and**
- **Creating the space and time for our clinicians to provide the continuity of care that is so important to our patients.**

Anchoring transformation around our neighbourhoods



Health and care organisations – **supported by the voluntary sector and driven by local Place Committees** – will deliver against these objectives by providing more services through Integrated Neighbourhood and Place Teams

Integrated Neighbourhood 'Teams of Teams', will evolve from existing Primary Care Networks which will work collaboratively to improve the health and wellbeing of the local population.

Wrapping integrated neighbourhood teams around our practices will enable them to deliver the majority of care to the population, providing long term continuity and cradle-to-grave care wherever possible.

Creating the system conditions to **enable our four Place-based partnerships or Alliances** to transform the way family doctors and other health and care professionals offer care locally as *Primary Care Networks* transition into locally-designed Integrated Neighbourhood Teams.

Shaping our approach with our communities

Building together

Engaged to build our approach & plan

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

Innovating locally

Enabled local exemplars

- ***Growing Health Together*** in East Surrey
- ***Guildford & Waverley Alliance*** appreciative enquiry approach
- **Equity Development Officers** in East Surrey
- Working with **Citizens Advice** to better understand financial challenges in our communities
- **Social prescribing** in some of our communities

Hard-wiring this approach by supporting Places to:

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

How the new model works – neighbourhood teams

1. **Creating a clear ‘Inbound’ and ‘Outbound’ model**

   Inbound - our Team of Teams streamlining urgent care same-day access delivered by a multi-disciplinary teams
   Outbound - The additional capacity releases time for GP practices to streamline things like medication reviews for patients with long term conditions and help patients avoid unnecessary appointments elsewhere in the health

2. **Rolling out cloud-based technology across our system**

   Enabling the seamless flow and re-direction of patients : offering ‘call-back’ functions to enhance patient experience, the ability to audit clinical encounters, and enables patient data to be easily accessible to aid clinical decision making.

3. **Improving demand and capacity responsiveness in primary care**

   A daily feed, directly from the clinical systems, allows us to see in near real-time any rising pressure, which can trigger an automated alert to the local teams who then respond by providing additional support to individual practices.

4. **Improving planned care**

   Integrated Neighbourhood Teams will be supported by a Complex Care Function operating right across Surrey Heartlands, bringing together hospital specialists, specialist therapies, diagnostic infrastructure and our virtual ward provision to deliver an improved Complex Care Function which will have significant impact on releasing capacity elsewhere in the system.

5. **Creating the physical space for our Team of Teams**

   Reimagining how we use Primary Care buildings to create a positive working environment for staff and be a catalyst to integration and to focus on patient needs when thinking about how we use our buildings in the future.

How the new model works – integrated same-day urgent care

Our approach

Developing effective, resilient, neighbourhood-based same-day access to urgent care that can serve as an easily-accessible first point of contact for patients with routine issues.

- Excellent triage
- Appropriate clinicians
- Patient experience and satisfaction
- Quality of care
- Overcoming local barriers
- Staffing

Leading to…

Enhanced Access Hubs – same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends;

Urgent Community Response - for our more complex and frail patients we will provide an MDT rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital;

Community Diagnostic Hubs – working across Place we have developed models of diagnostics that are placed within local communities, including outreach models such as working with the homeless communities who can now access mobile Hep C screening and liver testing as well as Covid Vaccination from an outreach Community Team;

Care Homes – we have implemented an MDT approach to the management of care for these residents, particularly those who are more complex requiring extra support to avoid hospital admission;

Frailty Models of Care - we have developed key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely.

Anticipatory Care Models – using our new digital risk stratification we can better target those most at risk of admission and attendance into the Urgent Care system

Creating the right space for our Teams of Teams

Finding the physical spaces for our teams to co-locate and work together to improve care is one of our main challenges

We have a dedicated team working across Surrey to identify joint opportunities around using buildings that could support the future integration of services. They are:

Baselining the whole estate – to understand the value, costs and condition of every building currently used for health, including the primary care (GP) estate;

Developing new Investment principles – to enable us to both prioritise investment and find new opportunities to develop estate;

Identifying opportunities to potentially consolidate existing sites to deliver wider objectives, for example, releasing value to support reducing system inequalities;

Developing a Blueprint Framework for the governance and delivery of multi-partner place-based projects.

Enabling us to:

1. Move to an approach that make **estates a catalyst to integration**
2. **Focus on patient needs** when thinking about how we use our buildings in the future
3. **Understand and explore the potential for new opportunities**, especially around the use of commercial estate
4. **Create a positive working environment for staff** -including adequate space for activities like training and teamwork.

Building expertise, developing talent & transforming recruitment

Modernising and integrating recruitment	By integrating recruitment across a range of partners we can help attract and share candidates across settings, ultimately ensuring individuals can benefit from access to multiple opportunities without having to complete multiple applications
Building new capabilities	The **Surrey Heartlands Health & Social Care Academy** will help to build, develop, share, and nurture talent across all settings. Using rotational programmes for students and other roles, we will augment the exposure to primary care, community health and social care settings to help attract and retain talent.
Developing fulfilling careers	Expanding Additional Roles Reimbursement Scheme in primary care and integrating workforce activities with social care will help enhance career opportunities in community settings. We're also trialing a Career Guarantee - offering two jobs at the same time in some career pathways – an initial role and a conditional offer for the next role
Establishing a 'Surrey Offer'	Teams of Teams will be more effective if we work toward ensuring equity of opportunity, access to support and experience – closing the disparity that currently exists. Also prioritising how access to things like affordable accommodation and financial well-being services can be accessed by all staff.
Supporting Learning and Development	The Health and Care Professional Leadership Framework will support leaders from across health and care through a 'system leadership' support offer, access to leadership academy programmes and profession-specific leadership development.

Transforming digital infrastructure and data to accelerate change

Our data integration and warehousing programme is helping create the platform for a **central data and analytics ecosystem** built on using of shared data across a range of partner organisations across Surrey including health, local authority, police and third sector

Already integrated all our major providers on the **Surrey Care Record**

Successfully rolled out remote monitoring and virtual ward platforms across the system

General practice is promoting the NHS App and NHS.UK to reach **60% adult registration by March**

Linking the Surrey Care Record to our Population Health Management platform will improve segmentation and give us the knowledge and information to enhance direct care of patient cohorts and support personalised, anticipatory preventative care, leading to:

An **Integrated Data & Digital Platform**	**A System Intelligence Function**	**A Population Health Hub**
Initially focused on developing a population health-based approach to health and wellbeing	To support place & neighbourhood teams to use our Integrated Data Platform to improve our predictive capability to support planning	To work with the wider system to promote, sustain and spread successful interventions and innovations

Making our approach sustainable

1. **Governance & decision making**

Decision making as local as possible, with the broader system leading on accountability and ensuring improvement, innovation, investment and support is targeted where it will have the greatest impact on patients and communities

2. **Quality Improvement**

Committed to continuous care quality improvement at every level of our system and have established the **Quality Improvement Collaborative** to drive our quality governance model across Place-Based areas and ICS. The Health and Care Professional Committee providing system-wide leadership across the spectrum of the quality agenda

3. **Supporting practice sustainability**

Undergoing a series of access visits to understand pressures and challenges that may be faced by General Practice to determine what additional support and improvements that may be made

How will we know when we are succeeding?

Access

Continuity

Reducing inequality

When every patient is able to access primary care easily, efficiently and receive the appointment type of their choosing

When we see an increase in personalised care being provided by multi-agency, multi-disciplinary teams with care co-ordinators: enabling patients to see the same clinicians or teams. We should also see a reduction in the number of ED attendances for defined cohorts of patients, an overall reduction in the number of GP contacts and a reduction in the number of outpatient contacts

When we see cohorts of patients being identified where there is clear inequality in terms of life expectancy, immunisation and screening, diabetes, cardiovascular prevention and early cancer diagnosis in populations who aren't routine health seekers: all of whom need to be able to be supported to have the care they need. Identifying and supporting these patients will also help to see a measurable impact in addressing the C20+5 gap

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Update to Surrey Health and Wellbeing Board from Frimley Integrated Care System - 15 March 2023

Frimley Integrated Care Partnership (ICP) and Frimley Integrated Care Board (ICB)

Since the last update report to the Surrey Health and Wellbeing Board in December 2022 the Frimley Health and Care Integrated Care Partnership (ICP) has been focused on refreshing its System Strategy: Creating Healthier Communities. Following on from the interactive strategy engagement ICP session in November last year, the system has focused on sharing the draft strategy with a wide range of partners across the ICS footprint to gain feedback and reflections to further iterate the strategy ahead of final endorsement and sign off at the March 2023 ICP Assembly meeting. Please note that the draft ICS strategy has been shared with the Surrey Health and Wellbeing Board as part of our engagement programme.

The Frimley Integrated Care Board (ICB) continues to implement its Board Development Programme and has met in both public and seminar sessions. Key items discussed include (but not exhaustive):

- Urgent and Emergency Care Strategy (including winter preparedness and response)
- Maternity Overview
- ICS Strategy
- Strategy and Planning
- Use of Resources
- Performance Oversight (quality, performance, finance, and workforce)

Frimley ICS Implementation of the Fuller Stocktake – Update Report

Introduction

The Fuller stocktake report makes a series of recommendations for local and national leaders and articulates important ideas about the future shape of urgent care and about the further development of neighbourhood teams. It is divided into four sections

• building integrated teams in every neighbourhood;
• improving same-day access for urgent care;
• creating the national environment to support locally driven change; and
• hard-wiring the system to support change.

While the report makes specific recommendations, it also outlines considerations with neighbourhoods/place teams might deliver, how that approach might staffed, and how its benefits can be supported by integrated care systems (ICSs) and national systems.

In Surrey Heath and Farnham we have developments in all 4 areas as detailed in the tables below:

Developments in Surrey Heath

Surrey Heath Primary Care Network profile	7 GP practices ranging from 7,000 to 28,000	10 sites	97,000 population

8

Report theme	Status	Development
Development of Integrated Neighbourhood Teams	Established Integrated Care Teams since 2014, providing anticipatory and reactive support for older people. Building on the track record of innovation and existing collaborative relationships between PCN and local partners, including community groups and charities. These strong relationships are at both operational and strategic level. Building and applying capability in population health management, led by the PCN. Focus on population cohorts and utilising the available workforce. E.g. revised approach to providing support for residents living with IBD through Health and Wellbeing Coaches linked to the wider community and secondary care team.	In 2022, a programme to 'refresh' our integrated care model was launched, engaging with all stakeholders and partners to realign priorities and explore new opportunities for further integration ensuring the benefits are felt by as many of our residents as possible. As an example, it has been identified that one of our next priority areas of focus for integration is working age mental health. Development of neighbourhood teams supporting children and families. Building on twilight paediatric nurse in primary care project and Early Years Speech and Language Therapy intervention in Primary Care pilot.
Streamlined access to urgent, same-day care and advice	Multi-disciplinary same day access from each practice. Established Urgent Community Response from the Integrated Care Team. Improved telephony systems at practices and use of online consultation. Emphasis on advice and signposting including use of apps/digital resources such as the Frimley Healthier together website and app. Using healthier together app "traffic light" system to streamline access.	Further alignment of telephony systems and centralisation through a hub model. Development of PCN level same-day care.
Proactive, personalised support	Long established Integrated Care Teams accept referrals for patients in need of	PCN participating in remote monitoring pilot of patient's resident in care home and

	review and proactively review patients identified as potentially having future need The existing infrastructure of integrated care allows us to 'plug in' strategic priorities such as population health initiatives to ensure shared ownership and collaboration in delivery. Examples of this include anticipatory care for individuals living with Frailty, work to improve health checks for individuals with learning disabilities and enhanced care and support to individuals living in care homes.	those identified as having complex health needs
Creating healthy communities	Whole system approach to obesity since 2021, led by Surrey Heath Borough Council and actively supported by the Surrey Heath Care Alliance. Health Creation Alliance learning programme being completed to address neighbourhood health inequalities in Old Dean Local Area Coordinator role active in the community of the Key Neighbourhood of Old Dean and also operating in St Michaels.	With partners, identify and work to address inequalities in access and outcome. Continue the community focused approaches, listening to residents and supporting the creation of community led solutions and changes.

Developments in Farnham

Farnham Primary Care Network profile	4 GP practices ranging from 6,000 to 18,000	4 sites including Farnham Centre for Health	50,000 population

Report theme	Status	Development
Development of Integrated Neighbourhood Teams	Long history of participation in local organisational development programmes,	Opportunity to increasingly share workforce across primary care and community

	pilots, innovations and the creation of the Farnham Together working group has resulted in a strong local relationship between the PCN and their system partners and communities	providers as services are reviewed
Streamlined access to urgent, same-day care and advice	Consolidated multi-disciplinary same day access service based at Farnham Centre for Health supported by paramedic led home visiting service	Alignment of improved telephony systems and online consultation products
Proactive, personalised support	Long established Integrated Care Teams accept referrals for patients in need of review and also proactively review patients identified as potentially having future need	PCN participating in remote monitoring pilot of patients resident in care home and those identified as having complex health needs
Creating healthy communities	Multi-organisational Health Inequalities Group, including patient representatives, ensures that Farnham population receives adequate attention to address their identified health needs Health Creation Alliance learning programme completed to address neighbourhood health inequalities Clinical Lead for Health Inequalities & Wellbeing Team appointed	PCN focus continues to be on the community who reside in Upper Hale with an application to access funding from the Surrey Better Care Fund recently approved. This project will focus on healthy eating education and support

Next Steps

Workforce, estates, and data will continue to be 3 of the key enablers to developing and driving our work forward as well as local implementation of the themes within the stocktake report – recognising that change needs to be locally led to suit the needs of the populations in which we serve.

Local efforts have been successful in recruiting to the ARRS roles, however there is scope to develop these roles and creating a better integrated local workforce and including primary care staff as a core part of the local NHS system.

Estates continues to be a pressure; space is limited and funding for additional or new space a major constraint. We are currently developing estates plans for longer term sustainability with our PCNs which consider access, population health and addressing inequalities. In the short term we are looking at opportunities to repurpose existing space and working with partners to utilise estates opportunities.

Data is another enabler which helps us design and develop services as well as understand our population and demand on the services we provide within our local systems. We have plans to further improve data and have an engaged digital first workforce who are innovating and improving our digital infrastructure.

We continue to work with community and system partners as well as local authority and patients to improve health outcomes using a population health approach whilst considering the wider determinants of health.

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