DRAFT FOR ENGAGEMENT

SURREY HEALTH AND WELLBEING STRATEGY

DELIVERING THE COMMUNITY VISION FOR SURREY

V.2. 25-02-18

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FOREWORD

I am delighted to present this ten year Health and Wellbeing Strategy for Surrey. It is the product of unprecedented collaboration between the NHS, Surrey County Council, district and borough councils and our wider partners, including the voluntary and community sector and the police.

We want the people of Surrey to live longer, healthier lives. We believe that people should be supported to look after themselves and those they care for, and have access to services when they need them. And we want to deliver better health and wellbeing outcomes within our budget.

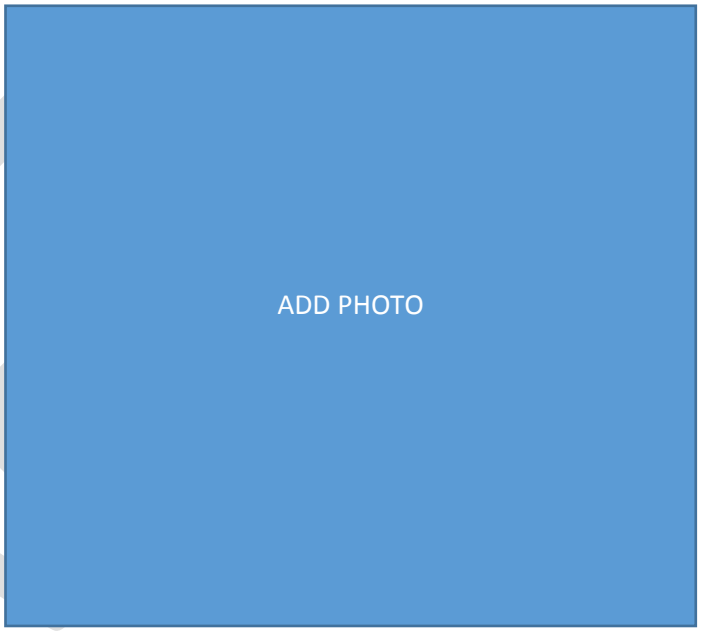
This strategy sets out how we can work together with our local communities to transform services across Surrey to achieve these aims.

Our strategy focuses specifically on the opportunities we want to work on together as a partnership. Delivering it will play a crucial part in achieving the '*Community Vision for Surrey in 2030*' which was the result of significant engagement with the Surrey population last year. It will also support the delivery of local health and care plans, how we respond to the NHS Long-Term Plan* and individual organisational strategies and plans (which include specific priorities that organisations will focus on themselves).

We have used a robust methodology to arrive at a set of priorities that all partners across Surrey recognise and support. We are committed to making a real change for the next generation by focusing on these areas and on those groups within the population who need more support.

We have been talking to our citizens about these issues for several years, and the ideas put forward in this document build on those discussions. This plan is only the first step in engagement with local communities, and acknowledges the importance of engaging further with the Surrey population if this strategy is to be truly meaningful.

We look forward to discussing our plans with you further.



Tim Oliver

Chair of the Surrey Health and Wellbeing Board & Leader of Surrey County Council

***** On behalf of each of our health and care systems; the Frimley and Surrey Heartlands Integrated Care Systems, and the Sussex and Surrey Sustainability and Transformation Partnership.

BACKGROUND

Over the spring and summer of 2018, Surrey County Council engaged with residents, communities and partners across the county to understand what Surrey should look like by 2030. Informed by these conversations, a shared vision for Surrey has been created:

> *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.*

Our ambitions for people are:

- Children and young people are safe and feel safe and confident.
- Everyone benefits from education, skills and employment opportunities that help them succeed in life.
- Everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing.
- Everyone gets the health and social care support and information they need at the right time and place.
- Communities are welcoming and supportive, especially of those most in need, and people feel able to contribute to community life.

Our ambitions for our place are:

- Residents live in clean, safe and green communities, where people and organisations embrace their environmental responsibilities.
- Journeys across the county are easier, more predictable and safer.
- Everyone has a place they can call home, with appropriate housing for all.
- Businesses in Surrey thrive.
- Well-connected communities, with effective infrastructure, that grow sustainably.

In light of the new community vision and the vital role people and organisations in the health and care system play in its delivery, partners initiated the development of a new Joint Health and Wellbeing Strategy for Surrey. This involved partners coming together to drive real change in how Surrey's residents are enabled and supported to achieve better health and wellbeing outcomes. The strategy recognises the importance of addressing root causes of poor health and wellbeing – including things like poor housing and the environment – and not simply focusing on treating the symptoms. It is intentionally ambitious.

The strategy sets out Surrey's priorities for improving outcomes across the population and a set of targets for the next 10 years. It identifies specific groups of people who suffer higher health inequalities and who may therefore need more help. And outlines how we need to collaborate so we can drive these improvements at the pace and scale required.

We recognise that the county of Surrey sits across three health and care partnerships (the Surrey Heartlands and Frimley Integrated Care Systems (ICSs), and the Sussex & East Surrey Sustainability and Transformation Partnership). These, along with other local partnerships, will be the key vehicles for delivery with no need for any additional governance or new structures.

The strategy focuses on a single set of agreed priorities for the county, in particular where we can effect change *as a partnership*. It is not meant to include everything, and therefore doesn't cover sector specific, organisational or local plans although these will all need to be aligned to this overarching work. As the Surrey Heartlands ICS is entirely within the county of Surrey, this strategy will form the core of its response to the NHS Long-Term plan (with additional information which is included in Appendix One). This strategy will also form part of the separate submissions made by both East Surrey and Sussex STP and Frimley ICS in their responses to the NHS Long-Term plan.

CONTEXT AND CASE FOR CHANGE

A picture of Surrey

Over 1.1 million people live in the county of Surrey, interacting with and having their needs addressed by:

Local Businesses

Police

Eleven District & Borough Councils

Six healthcare trusts

Surrey County Council

Community healthcare providers

GP practices and other primary care providers

Six Clinical Commissioning Groups

Fire and Rescue Service

4,500 - 6,000 VCFS organisations

Approximately 386 schools & academies

Higher and further education establishments

Three health & care partnerships (ICSs/STP) - and their respective Integrated Care Partnerships (ICPs)

Surrey is one of the most densely populated shire counties in England, with almost one in five of the population aged 65+ and life expectancies amongst the highest in the country.

Only 8.8% of children in Surrey are from low income families, with Surrey being within the top 10 least deprived counties in England. People in Surrey on average are relatively healthy, with obesity prevalence in children at almost 7% lower than the national average. Additionally the employment rate in Surrey is again above the national average at 77.7%, with children on average succeeding academically with over 65% of children achieving 5 or more GCSEs at grades A*- C.

Although on the whole Surrey is widely perceived as a 'healthy and wealthy' county, it is not without its share of challenges. It is estimated that 10,600 5 to 15 year-olds in Surrey have a mental health disorder.

Similarly, there is considerable variation in deprivation, with over 23,000 children in Surrey living in poverty, which is linked to poor health and wellbeing outcomes for them and their parents.

Whilst there remain areas that need to be improved, the system already has a number of strategies and agreements to tackle these challenges, including the *Community Vision for Surrey in 2030* and the *Surrey Heartlands devolution agreement* which gives more local freedom to decision-making and pooling of budgets. As a result Surrey has been able to develop momentum to start working together on achieving its desired outcomes.

Surrey has the opportunity to capitalise on the assets and resources available, including the ability to work collaboratively across organisations, to address challenges and improve outcomes for the people of Surrey.

A more detailed understanding of Surrey's population and the opportunity is detailed in appendix two (Priority Area Scorecards).

Understanding the health and wellbeing of our population

We have used the life phases of *Start Well*, *Live Well*, and *Age Well* as a framework for understanding the current health and wellbeing of our population. The *Surrey Joint Strategic Needs Assessment* has provided a comprehensive source of information to inform our strategy.

This analysis has helped us define the opportunity for generational and sustainable long-term change through:

- Improved health and wellbeing outcomes for the population;
- A reduction in health and care activity; and
- Reducing the financial burden on the public sector.

We intend to use this plan to drive an ambitious push for change, rather than simply reacting to short-term challenges. Surrey has an abundance of assets and resources we can capitalise on to think and work differently.

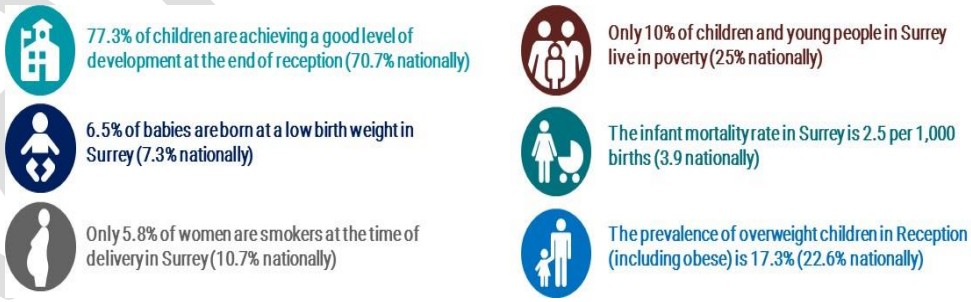
This strategy outlines our key priority areas, the evidence base to support this and a plan of what needs to change across partners in the system to deliver this change.

Starting well in Surrey

There are over 70,000 children under the age of five in Surrey, out of a total population of approximately 1.1 million, with needs that vary greatly across the county.

It is widely known that the first five years of a child's life are critical to their future development. These years are therefore an important foundation for building caring, productive and healthy families and communities. Helping children get the best start in life is both good for them and good for our society.

Early years' indicators depict Surrey on the whole as performing well compared to the national average and to the region:



However, in Surrey there are also pockets of inequality, which have a significant impact on those children's outcomes - both health related and more widely. The Income Deprivation Affecting Children Index indicates that whilst overall 10% of Surrey's children are impacted by income deprivation, in the worst affected areas over 40% are affected. Where poverty exists, it is also frequently accompanied by higher incidence of poorer average health, obesity, isolation and difficulty accessing local support services.

Living well in Surrey

Most people in Surrey lead healthier lives than the average UK citizen.

However, this strong average performance often masks areas of underperformance, inequality or where additional focus is required for the future.

Areas where Surrey performs well:

- Healthy life expectancy at birth (Female): 68.1 years (63.9 nationally)
- Healthy life expectancy at birth (Male): 68.9 years (63.3 nationally)
- People reporting low life satisfaction: 3.7% (4.5% nationally)
- Unemployment: 3.4% (4.8% nationally)
- Utilisation of outdoor space for exercise/health reasons: 20.5% (17.9% nationally)
- Employment rate (aged 16-64): 79.5% (74.4% nationally)
- Income deprivation: 7.0% (14.6% nationally)
- 16-17 year olds not in education, employment or training: 4.3% (6.0% nationally)
- Excess weight in adults (aged 18+): 55.9% (61.3% nationally)
- Smoking prevalence in adults (aged 18+): 10.9% (14.9% nationally)
- GCSEs achieved: 65.6% (57.8% nationally)

Areas of inequality and underperformance:

- 22% of all adults and 13% of all children in Surrey are obese, with the rate of adult obesity increasing at an average of 18% per year since 2014 (obesity and excess weight rates are 13.5% higher in deprived wards than the average Surrey ward).
- The proportion of people in Surrey living in overcrowded homes is set to rise by 5% over the next 10 years, specifically for the population living in more deprived wards.
- Smoking rates in Surrey amongst routine manual workers are 15% higher than average Surrey rates.
- In relation to educational attainment, children who qualify for free school meals in Surrey have considerably worse performance than the average child receiving free school meals across England.
- Surrey's employment rates for adults with learning disabilities has decreased by 35% since 2011.

Ageing well in Surrey

Over the next 10 years, the number of people aged 65+ living in Surrey is expected to rise by over 18%. As this population cohort grows in size, Surrey can also expect an increase in the number of people with complex conditions such as dementia, chronic kidney disease and other conditions related to ageing.

A further impact of Surrey's ageing population is that by 2023 the number of carers aged 85+ will have increased by 31%, with only a total 8% increase expected in the number of carers across all ages.

Dementia is a particular issue in Surrey. Compared to the peer group average in 2016/2017, the ratio of hospital inpatients with dementia was 11% higher in Surrey. Furthermore the level of hospital emergency admissions for patients aged 65+ with dementia is also 12% higher in Surrey. The higher life expectancy in Surrey is likely to be a contributing factor. With a high predicted growth in the over 65 population, this challenge is only likely to grow, meaning a greater focus on prevention and early support.

Supporting this cohort will need to be done through a partnership approach as there is no one organisation that can do this alone.

As of 2017 18.7% of the population in Surrey was aged 65+ (18% nationally) where the range per locality is between 23% and 16.3%,

Approximately 1 in 25 people aged over 65 in Surrey lived in care homes in 2015, which is expected to increase by 60% by 2030.

It is estimated that there are approximately 22,000 people with frailty in Surrey currently, expected to increase by almost 30% by 2030.

Citizen engagement

It is critical that alongside the data we have about people's health and wellbeing, we understand and act on the feedback we get from our citizens. Citizen engagement has and will continue to form a vital role in the design and delivery of this strategy – of which there are three key phases:

Phase one: Using the feedback we have.
In developing our strategy, we have used a wide range of resident and patient feedback to inform our priorities. These include the findings from: the quarterly Surrey Residents' Survey; the Connected Care Survey; the Mental Health Survey; and the widest resident engagement exercise ever undertaken by Surrey County Council in the development of the Surrey 2030 vision. Alongside this, our stakeholder workshops involved Healthwatch Surrey and a range of service user / patient representative organisations to ensure a strong resident / patient voice, alongside the expertise of key stakeholders.

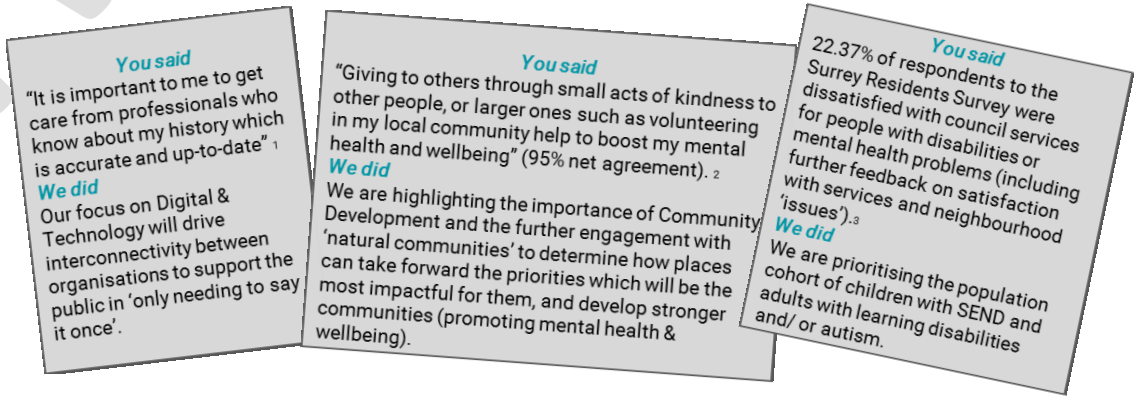
Phase two: Publishing the draft plan to test it.
Whilst we are confident that the approach we have taken to develop this draft strategy was robust – based on evidence, resident / patient views and the expertise of professionals working across the system - it was important to make this draft strategy available for people to comment on. This will help test that we've got it right and that we have translated the evidence available into a set of priorities and ambitions that are clearly understood and recognised. So we're now asking for your feedback before taking the draft strategy to the Health and Wellbeing Board for approval.

Phase three: co-design and co-production
Our strategy is ambitious – we want to secure the best health and wellbeing outcomes possible for our population. But no single organisation or group of organisations can do this without the active involvement of citizens – i.e. residents, patients and carers.

Partners across Surrey are committed to working with residents to co-design and co-produce the solutions we need to achieve the outcomes described in this strategy. We know this will require partner organisations to work differently and to redefine how citizens and our organisations work together.

We're embedding this as one of the key enabling programmes ('system capabilities') described later in this document to help ensure we maintain our focus on citizen engagement and involvement.

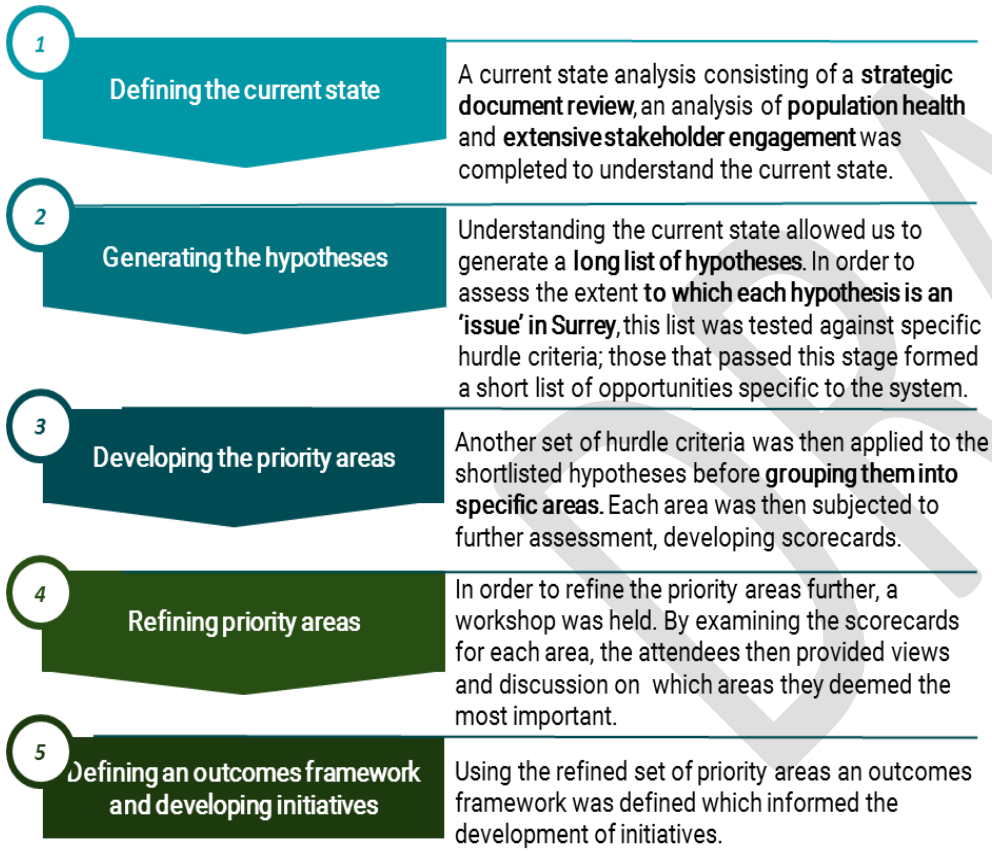
We've already put the findings from the feedback citizens have given us to good used, as described in 'phase one' above. These rich sources of insight have been used to shape our priorities – for example:



PRIORITIES FOR SURREY

Approach

We used an evidence based approach in developing our strategy, so that we focus on Surrey's greatest challenges and, where appropriate, target the groups of the population that need additional help to achieve their target outcomes. This approach is summarised below and further details can be found in Appendix four (methodology and approach).



Priority areas and population groups

Surrey will focus on three interconnected priorities: ***fulfilling potential***, ***leading healthy lives*** and ***having good emotional wellbeing***.

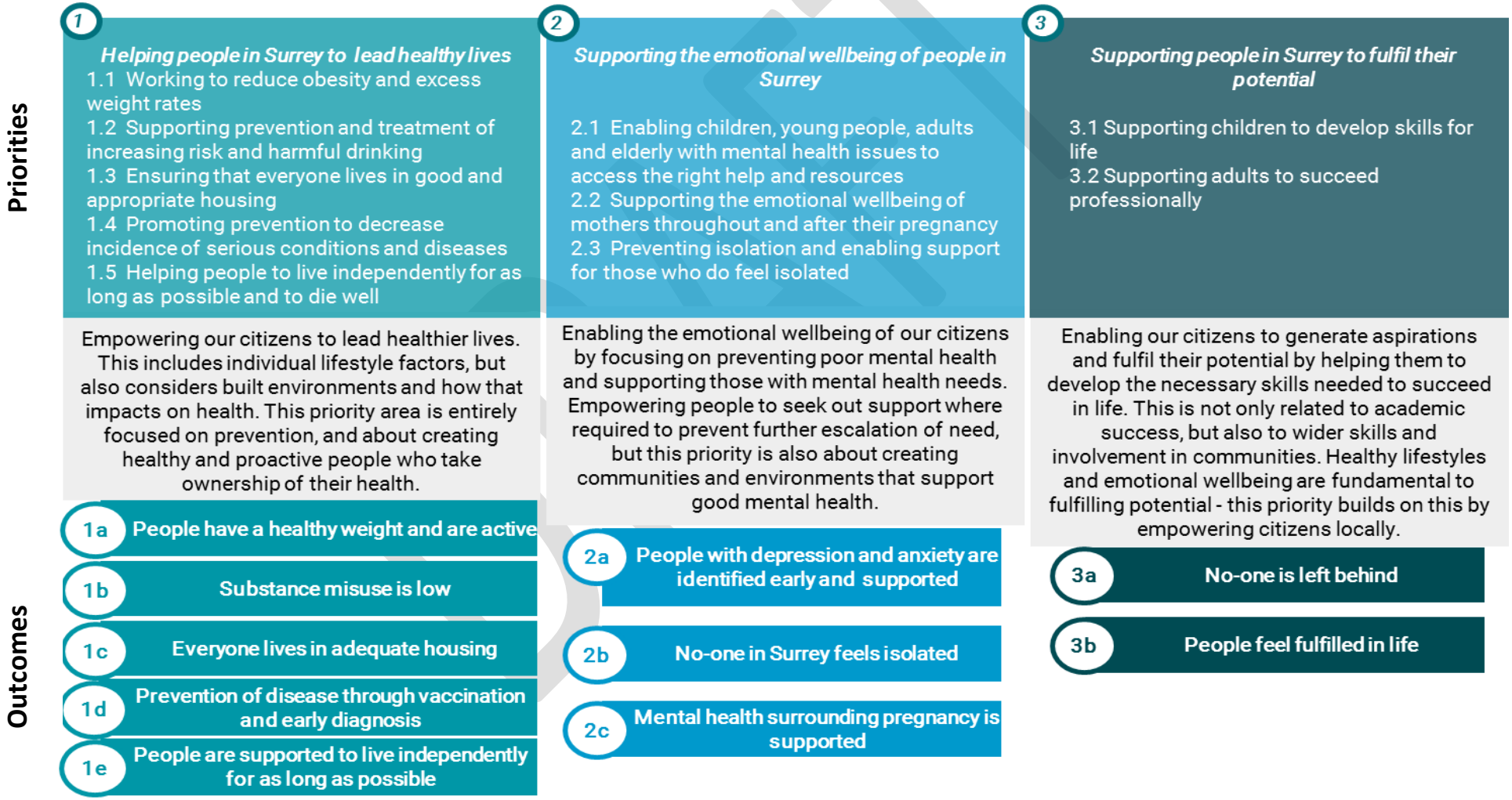
To avoid any groups of the population being left behind, Surrey will focus on tackling these priorities across the entire population, as well as within some specific groups of people which are often overlooked or most at risk.

These priorities and target groups – described in more detail over the next two pages - have been identified based on extensive data and benchmarking analysis as well as stakeholder engagement across the county. They focus on prevention in its earliest form, and on providing the right 'place' for the population to thrive and reach their full potential.

The target outcomes for each priority focus on areas where Surrey has been underperforming, or where performance has been deteriorating. This allows for the plan to take a targeted approach in improving outcomes for those who would benefit the most whilst also creating clarity for the system on the direction of travel and long-term vision.

Surrey's priorities and outcomes

Surrey's selected priorities are described below - these have been categorised for pragmatism, but we recognise the fundamental importance of mental health and wellbeing as connected parts of living health lives; and the role of good physical and mental health in enabling people to fulfil their potential. Outcomes have been identified for each priority - these are the goals and overall targets the system will work towards for our population. Specific metrics for measuring these outcomes per cohort have been identified to allow a clearer understanding of progress and measurement of the target outcomes. The detailed methodology and outcomes matrix is included in Appendix Four (methodology and approach).



Surrey's priority population groups

The aim of this strategy is to address outcomes for the whole of Surrey - driving change across the population at pace and scale. However, it also recognises that specific groups of people suffer disproportionate inequalities in outcomes, and therefore may require specific and targeted support/resource to bring their outcomes to be on par with the wider population. We have identified these priority groups below.

A General Population

This refers to the entire population of Surrey. This plan aims to address the wider determinants of health and wellbeing for all of Surrey, with a strong focus on prevention.

B Children with SEND and Adults with Learning Disabilities and/or Autism

Children with special education needs and disabilities, and adults with Learning Disabilities and/or Autism. The focus is on improving the outcomes for this cohort and on providing opportunities for them to achieve their potential.

C Young and Adult Carers in Surrey

All young and adult carers in Surrey. The focus is on supporting this population cohort and creating opportunities for this cohort to be part of their local community and as a result avoid feeling isolated.

D People who need support to live with illness, live independently, or to die well

Those people living with illness, including long term conditions, multimorbidities, people who require support to live independently, and people who require support to die well. Our focus is to promote self management where possible, independence, and use of community assets and resources.

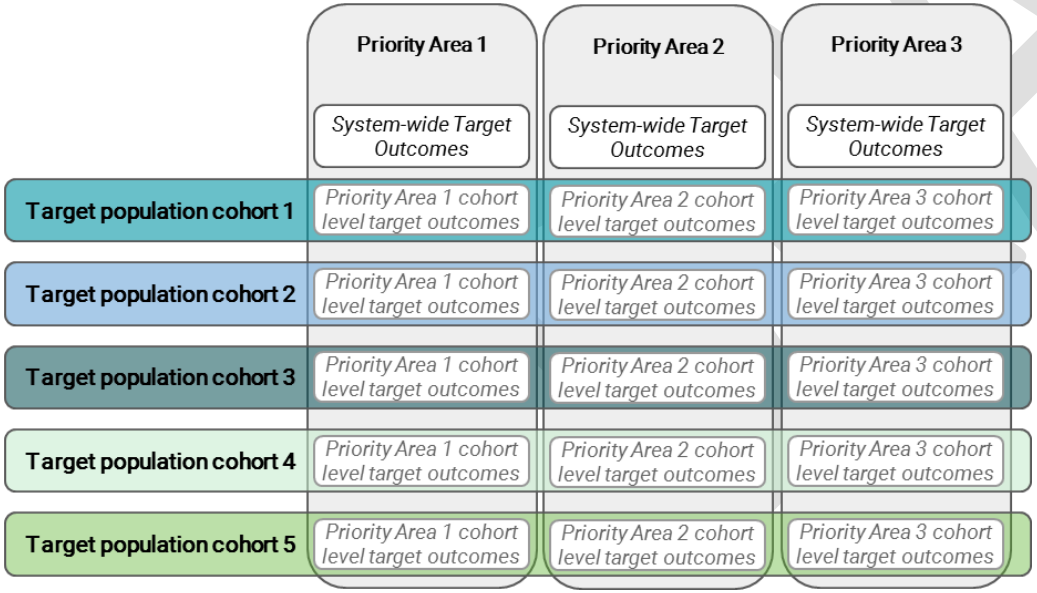
E Deprived or vulnerable people

Those people living in deprivation, or those who are vulnerable across Surrey. This includes children in care and care leavers. The aim is to place a focus on this cohort which based on indicators has been left behind in the past, and improve their health outcomes.

Measuring and tracking success and delivering ambition at a population group level

Fulfilling potential, leading healthy lives, and having good emotional wellbeing have different meanings and implications depending on the environment and conditions for each individual. So whilst the system-wide priorities remain the same for each population group, the definition of success has been adapted to each target population group. This is to avoid the overall positive outcomes for the wider population masking the existing areas for improvement and poor outcomes for specific groups.

Identifying how the system-wide outcomes relate to each population group helps us measure and track success more clearly. In addition, this puts a specific focus on those groups who may have been left behind in the past, or may not have had their outcomes measured or addressed in a way that delivers the greatest impact.



Our priority groups in more detail

This section describes each of our priority population groups in a bit more detail – for each one you'll find:

- A definition of the population group
- A description of the difference we're trying to make through some key measures of success – this includes 10 year outcome targets and the financial and activity impact
- A description of example initiatives or programmes we have identified – these are not the explicit initiatives that will be implemented but provide a view of how outcomes may be achieved and how we can capture learning from best practice elsewhere to deliver improved outcomes
- A description of how we will need to work together differently as partners to achieve our ambitions ('building capabilities').

Appendix Four describes how we have developed the measures and targets for each of these population groups. The use of further measures identified through recent engagement activity is also being explored – a summary of these additional measures is captured in Appendix Six.

Population group one - *general population*

Definition:

General population - this refers to the entire population of Surrey. This plan aims to address the wider determinants of health and wellbeing for all of Surrey, with a strong focus on prevention.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance		Target Performance	10 Year Target Outcomes Impact: Financial Impact
People feel fulfilled in life	Reported low life satisfaction	3.7%		3.2%	To be added when the finance / activity modelling has been completed
People have a healthy weight and are active	Obesity admission rate per 100,000 population	East Surrey CCG	499	236	
		G&W CCG	551	510	
		North West Surrey CCG	473	499	
		Surrey Heath CCG	876	682	
		Surrey Downs CCG	382	220	
		NEH&F CCG	374	194	
Substance abuse is low	Successful completion of alcohol treatment	32.2%		51.8%	
Prevention of disease through vaccination and early diagnosis	Vaccination rates	DTaP/IPV/Hib	88.1%	98.4%	
		Pertussis	82.9%	92.9%	
		MMR	81.7%	93.6%	
		Rotavirus	89.0%	95.3%	
	Diabetes diagnosis rates	69.4%		79.1%	
	Bowel cancer screening coverage	60.6%		65.3%	
People with depression and anxiety are supported	Depression prevalence	East Surrey CCG	7.0%	6.2%	
		G&W CCG	7.5%	6.2%	
		North West Surrey CCG	6.2%	6.5%	
		Surrey Heath CCG	6.3%	5.3%	
		Surrey Downs CCG	6.8%	6.2%	
		NEH&F CCG	8.6%	6.5%	
	Anxiety prevalence	19.5%		14.1%	

Outcome metrics 'Mental health surrounding pregnancy is supported' and 'No-one in Surrey feels isolated' have not been modelled due to the availability of data.

The general population - examples of supporting initiatives

1. Use of community assets and local organisations to promote healthy lifestyles across Surrey

- Improving the wellbeing of people across Surrey through **local-level initiatives**, including:
  - Improving physical activity access through utilising local assets (parks, greenspaces);
  - Improving access to healthy food through farm stands and corner stores;
  - Promoting neighbourhood safety by addressing pedestrian safety and crime challenges; and
  - Coordinated school health programmes.
- Communities with specific challenges are selected, and based on the available local assets, a **coalition of local organisational leaders** is put together to **oversee the programme** and multiple initiatives (multi-organisational).
- Example initiatives: farm stands set up at local schools and joint-use agreements set up for school playgrounds and parks in schools to promote physical activity and healthy eating promotion.
- Where this has been implemented a **30% reduction in perception of barriers to physical activity** was realised, where this correlated with an increased usage of neighbourhood assets and **improvements in physical activity utilisation behaviours by 20%.**
- Furthermore a **20% increase in awareness of barriers to healthy food access was realised**, with an increased utilisation of local good retail outlets.

2. Mental health first aid training of the Surrey-wide workforce

- Whilst to date there are some organisations across Surrey which provide basic mental health first aid training to their workforce, this would be the opportunity to train employees **across all organisations in Surrey** to be mental health first aiders. This would include both public sector organisations a part of the Surrey-wide partnership, but also **further organisations and businesses** (e.g. local businesses).
- Where mental health first aid training has been implemented in their workplace;
  - 91% of employees surveyed have said there had been an **increased understanding of mental health issues**;
  - 88% reported an **increase in confidence around mental health issues**;
  - 87% said **more mental health conversations were happening at work** as a result of the training;
  - 83% noticed an **improvement in procedures for signposting to further support**; and
  - 59% reported an **increase in help-seeking behaviour.**
- This initiative would focus on a Surrey-wide, partnership driven, promotion of mental health first aid training in partnership and wider organisations.

Sources: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5874305/, http://www.ssehsactive.org.uk/userfiles/Documents/eonomiccosts.pdf, https://www.thelancet.com/action/showPdf?pii=S0140-6736%2812%2960766-1, https://mhfaengland.org/mhfa-centre/news/mentor-study-research/, https://mhfaengland.org/individuals/adult/2-day/

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population	High	High	Medium
Deprived	High	High	Medium
People with SEND and LD/Autism	Medium	Medium	Low
Young and Adults Carers	Medium	Medium	Low
Living with illness & ill health	Medium	Medium	Low

Potential Finance and Activity Impact of initiatives*

Promoting Healthy Lifestyles	Mental Health First Aid
£	£
X	X

* To be added when the finance / activity modelling has been completed.

The general population - building capabilities

In order to implement these types of initiatives successfully, we will need to engage with all the necessary partners from within health and social care and beyond, and put in place the governance and infrastructure to enable the successful delivery of the initiatives. To achieve the target outcomes for the general population we will build the following types of capabilities:

Community development

- Progressing forward with the 'Surrey deals' being developed by Surrey County Council to agree clear 'pledges' with the community.
- Agree the communications and engagement strategy to be translated at the local level (district & borough) to co-develop initiatives with local people.
- Agree how that strategy interacts with the local workforce to create a two-way loop for feedback.

Clear governance

- Agreement on Health and Wellbeing Board responsibilities in relation to all of the outcome targets.
- Communication to the general public of the outcome targets and governance to be used to create accountability.

Estates

- Public sector estates strategy that encourages community based, multi-organisational provision to focus on building stronger asset-based communities.

Workforce and culture

- Development of a multi-organisational workforce deal to promote public sector employment in Surrey and to grow the required capabilities.
- Define the required culture, value and behaviours required by the workforce, including system leadership to achieve the target outcomes.

Programme management

- Define and embed programme and project management support capable of managing multi-agency projects across the general population.
- Create a central view of existing local and system-wide initiatives across Surrey to undertake portfolio management activities to identify areas of duplication and overlap.

Digital and technology

- Scoping of existing digital and technological capabilities and maturity across key system partners to identify need or gaps in capability to be able to effectively work collaboratively.
- Development of system interoperability to enable data sharing across organisations for early identification and support where appropriate.
- Development of system network, enabled digitally, to enable clearer signposting by partners.

Intelligence

- Refining of the information captured and metrics measured by the system (e.g. measuring indicators such as fulfillment or happiness across Surrey).
- Utilisation of geographic data across organisations to better equip local systems to develop targeted and universal initiatives for their populations.

Devolution / alignment of incentives

- Funding agreements determined based on priority areas and prevention.
- Ability to alter statutory requirements of services in line with the target outcomes.
- Ability to pool budgets and subsequently jointly fund initiatives and services.

Population group two – *children with special education needs and disabilities (SEND) and adults with learning disabilities and / or autism*

Definition:

Children with special education needs and disabilities, and adults with learning disabilities and/or autism - the focus is on improving outcomes for this group and on providing opportunities for them to achieve their potential.

The difference we're aiming to make:

				10 Year Target Outcomes Impact
Outcomes	**Metrics for Measurement**	**Current Performance**	**Target Performance**	**Financial Impact**
Adults with LDs/Autism feel fulfilled in life	Adults with LDs in employment	10.0%	16.4%	Data unavailable
People with LDs live in adequate housing with the adequate support	Rates of people with LDs living in settled accommodation	67.7%	82.4%	

Children with SEND and adults with learning disabilities and / or autism - examples of supporting initiatives

1. Implementation of community interest groups led by adults with learning disabilities

- Community coordinators, established by the partnership, **enable people with learning disabilities to set up and run interest groups in their local areas.**
- People are supported to shape their ideas, identify locations, invite group members and **make groups a reality in their local communities.**
- The established groups **draw on community assets** to facilitate activities (e.g. through equipment donation from local businesses, use of existing under utilised estates or co-locating groups with other activities to facilitate greater community join-up).
- Where this has been implemented nationally it has had a **transformative impact of the wellbeing** of both group leaders and group members.
- Participants have since gone on to **achieve qualifications, further volunteering activities or employment.**
- Additionally it has contributed to the **changing of perceptions** of people with learning disabilities and/or autism, and has developed new networks across VDFS and local businesses.
- In the context of Surrey the partnership would be able to use its respective data and information, or if possible join up this information, to better **understand individuals with learning disabilities who require support and in which communities.**

2. Shared Lives model for those with learning disabilities

- **Individuals with learning disabilities either live, or regularly visit households in the community,** in order to improve wellbeing and sense of community.
- This would require the household carers to be **appropriately trained and approved,** as well as those provided with payment.
- Where this has been implemented nationally this has improved the wellbeing for people with learning disabilities through;
  - **Sense of permanency;**
  - **Security stability**; and
  - **Consistency of residing with one household for an extended period of time** (often years).
- Furthermore a **higher quality of care** was experienced (on average) with 92% rated as good / outstanding and 0% rated as inadequate.
- An average £26,000 reduction in cost of care per person with learning disabilities compared to existing packages was experienced.
- In addition to the benefits gained for the individual, this initiative focuses on building stronger communities that support each other, which includes those currently providing care for those with learning disabilities.

Sources: https://www.communitycatalysts.co.uk/wp-content/uploads/2018/06/The-Do-Your-Thing-project-published-report-November-2017.pdf, https://sharedlivesplus.org.uk/images/300718_SLP_England_LR.pdf, https://www.socialfinance.org.uk/sites/default/files/publications/sf_shared_lives_final.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population			
Deprived			
People with SEND and LD	High	High	High
Young and Adults Carers	Low	Low	Low
Living with illness & ill health			

Potential Finance and Activity Impact of initiatives*

Community interest groups	Shared Lives
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Children with SEND and adults with learning disabilities and / or autism - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For children with special education needs and disabilities, and adults with learning disabilities and/or autism we will build the following types of capabilities:

Community development

- Developing a clear network of the existing VCFS and system-partners working with children with SEND and adults with LDs across Surrey. This allows for a stronger gathering of existing insights of cohort.
- Promotion of community level engagement to co-develop initiatives based on local needs of children with SEND and adults with LDs.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts' needs.

Estates

- Mapping exercise of existing estates utilised to provide care and support for children with SEND and adults with LDs, to identify opportunities for co-location and more focused community based provision.
- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access.

Workforce and culture

- Development of workforce 'passport' to allow those who work with children with SEND and adults with LDs to move between organisations to share knowledge, experience and practice.
- Workforce development to train all staff to better recognise and provide for the needs of this cohort, and feel confident in an appropriate response.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects for children with SEND and adults with LDs. This provides an opportunity to understand where there may be duplication in the system as well as existing gaps resulting in a fragmented offer for children and adults.

Digital and technology

- Understand the existing digital maturity of system partners in providing care and support to this population cohort. This allows for understanding where there are gaps in allowing for system interoperability but also where there are opportunities to use technology differently in service provision and in enabling people to live independently.
- Development of system-wide place strategy for utilising digital and technology in the provision of care for this population cohort.
- Development of system network, enabled digitally, to enable clearer signposting by partners.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort.

Devolution / alignment of incentives

- Ability to alter statutory requirements of services for those with Learning Disabilities and / or Autism in line with the target outcomes and wider determinants.
- Ability to pool budgets and subsequently jointly fund initiatives and services for those with Learning Disabilities and / or Autism.
- Payment reform of services for those with Learning Disabilities and / or Autism to align incentives across the system.

Population group three – *young and adult carers*

Definition:

All young and adult carers in Surrey. The focus is to develop more support for carers and create opportunities for them to feel part of their local community to avoid feeling isolated.

The difference we're aiming to make:

				10 Year Target Outcomes Impact
Outcomes	**Metrics for Measurement**	**Current Performance**	**Target Performance**	**Financial Impact**
Carers are supported to lead balanced and fulfilling lives	Carer-reported quality of life (out of 12)	7.9	8.4	To be added when the finance / activity modelling has been completed

Outcome metrics 'Rates of unpaid carers' and 'No-one in Surrey feels isolated' have not been modelled due to the availability of data.

Young and adult carers - examples of supporting initiatives

1. Identification and support of young carers through community pharmacies

- An initiative to **partner with pharmacies** across Surrey to improve the early identification of young carers and their families, and supporting pharmacies to engage with carers to provide the appropriate support.
- This would require:
  - **Training pharmacy staff on issues affecting young carers**;
  - **Carers' champions in pharmacies**;
  - **Confidential referral process**;
  - **Support information in pharmacies**; and
  - **Shared learning**.
- The benefit of this initiative is that young carers and their families are **identified early** and in their local communities, leading to timely assessment and / or engagement with appropriate support services.
- Furthermore through early identification, young carers and their families receive **early support and inappropriate caring roles are prevented or removed at an early stage.**
- As a result young carers and their families are able to make **better use of pharmacy services**, and there is an improved understanding of the processes in place for dispensing medicines to young carers.
- The use of pharmacies is an **ideal route to engage meaningfully with young carers** as it is in their local communities and at locations they already frequent.
- *It should be noted this work is currently underway in Surrey.*

2. Carers health and wellbeing programme

- Currently there are a number of VCFS organisations across Surrey providing care and support for both young and adult carers. This initiative would be focused on **a partnership approach to a carers health and wellbeing programme, pulling on partnership working beyond what currently exists across Surrey.**
- This initiative is a focused programme which **promotes the encouragement of carers to take ownership of their physical and emotional health** through;
  - **One-to-one support** by a multi-skilled individual who can effectively coordinate needs across multiple organisations; and
  - **Awareness raising** across the partnership and with local businesses.
- The goal of this initiative, and what has been realised elsewhere through similar programmes, **is an increase in access to social activities, increase in confidence and reduced stress / anxiety of carers.**
- A number of health and wellbeing initiatives related to Carers are already embedded through existing workstreams across Surrey.

Sources: https://professionals.carers.org/sites/default/files/the_young_carers_pharmacy_project_evaluation.pdf, https://www.carersleeds.org.uk/wp-content/uploads/2016/02/Carers-Leeds-report-FINAL-.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfill Potential
General Population			
Deprived			
People with SEND and LD			
Young and Adults Carers	High	High	High
Living with illness & ill health	Low	Low	Low

Potential Finance and Activity Impact of initiatives*

Young carers and pharmacies	Carers Health and Wellbeing
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Young and adult carers - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. To achieve the target outcomes for young and adult carers we will build the following types of capabilities:

Community development

- Requirement to work with the existing VCFS organisations that directly support carers (for example Action for Carers) to create clarity on this cohort and their needs. This cohort is often difficult to identify and therefore to support, and therefore using local knowledge will be integral.
- Promotion of community level engagement to co-develop initiatives locally based on this knowledge, for example with local community navigators.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- There is no one clear organisation accountable for the outcomes of this cohort, and therefore clear multi-organisational accountability and governance must be developed and communicated (e.g. Surrey Young Carers Strategy Group and Young Carers forum which oversees the implementation of the joint multi-agency Surrey young carers strategy).

Estates

- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access, use and self management of needs.
- This strategy can utilise existing estates to co-locate provision or information for carers alongside those services they most often require (e.g. mental health support, community based activities to reduce social isolation).

Workforce and culture

- Workforce development to train all staff to better identify and understand carers and be able to signpost effectively to meet the needs for this cohort.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects for carers, possibility building specifically on the existing capability within the VCFS.
- It is likely carers may be an aspect of wider reaching multi-agency projects, and therefore utilise programme management to identify the interdependencies proactively and effectively.

Digital and technology

- Development of a system network, enabled digitally, to support clearer signposting for carers and access to useful information. This can include the use of existing digital platforms which exist across Surrey which are to be joined up between system partners and iterated on a local level.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort (e.g. support for implementing housing initiatives to contribute to better outcomes for young adult carers).
- This includes the identification of additional metrics to better understand and predict outcomes for carers (e.g. Carers alert thermometer for young carers aged 11-18, Zarit Carer Burden Scale)

Devolution / alignment of incentives

- Additional benefits of devolution to be explored.

Population group four – *those who require support to live with illness, live independently, or to die well*

Definition:

Those people living with illness, including long term conditions, those with multiple conditions, people who require support to live independently, and people who require support to die well. Our focus is to promote self-management wherever possible, greater independence and use of community assets and resources.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance	Target Performance	10 Year Target Outcomes Impact: Financial Impact
People live in appropriate housing with easy access to the services they need	Excess winter death index	12.4	8.7	To be added when the finance / activity modelling has been completed
	Rates of supported working age adults whose accommodation status is severely unsatisfactory	15%	14%	
People live independently at home for as long as possible	Rates of older people still at home 91 days after discharge from hospital	69.9%	91.2%	
	Emergency admissions rates of those with dementia per 100,000 population	3,272	2,496	
People in Surrey die well	Rates of deaths in usual place of residence in those aged 65+	49.4%	55.2%	

Outcome metrics 'No-one in Surrey feels isolated' has not been modelled due to the availability of data.

Those who require support to live with illness, live independently, or to die well - examples of supporting initiatives

1a. 'Virtual Hospital'

- An initiative to support people to stay out of hospital and reduce their lengths of stay through **enabling patients to receive consultant-led medical care in their homes.**
- This would be as an **alternative to waiting in a hospital bed in advance of a next procedure**, and with the goal of improving the wellbeing of patients by allowing them to be able to recover in their home.
- Where this has been implemented elsewhere 87% of appropriately referred patients were able to stay at home, **saving over 220 bed days**.
- There is the opportunity to extend this initiative further to involve more system partners, for example **community based programmes to promote health and independence following medical treatment** enabled by joining up of information between organisations.

1b. Enhanced health in care homes - medication management

- Supporting care homes to have an **effective 'care home medicines policy'** which aims to avoid unnecessary arm, reduce medication errors, and optimise the choice and use of medicines with care home residents.
- This would be a joint initiative between health and care to improve medicines management leading to better health and wellbeing for residents.

2. Improving the mental health and wellbeing of people living with long term conditions

- Innovative forms of liaison psychiatry have demonstrated that **providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals.**
- This initiative would therefore drive **collaborative care arrangements between primary care and mental health specialists** to improve outcomes with no or limited additional net costs.
- CCGs would prioritise **integrating mental and physical health care** more closely as a key part of the strategy to improve quality and productivity of health care.
- An example of this could include the inclusion of a psychological component in a breathlessness clinic for COPD in an acute provider.

3. Multi-generational Care Homes and 'Rent a Granny' Schemes

- Initiatives that focus on integrating the ageing population into their community, providing opportunities for fulfillment and thinking differently about what living with LTCs and dying well means are able to be implemented across Surrey **at a local level**.
- 'Rent a Granny' as an example, already active in parts of Surrey, focuses on identifying members of the ageing population and families in the community who would **mutually benefit from social interaction.**

Sources: https://www.kingsfund.org.uk/blog/2018/10/better-value-and-better-nights-sleep, https://www.thetelegraphandargus.co.uk/news/15317496.virtual-elderly-care-ward-wins-national-award/, https://www.kingsfund.org.uk/sites/default/files/2017-11/Alison_and_Maj.pdf, https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640714/Commissioning_effective_mental_health_prevention_report.pdf

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfil Potential
General Population			
Deprived			
People with SEND and LD			
Young and Adults Carers			
Living with illness & ill health	High	High	Medium

*Potential Finance and Activity Impact of initiatives**

Virtual hospital & meds management	Collaborative mental health
£	£
X	X

* To be added when the finance / activity modelling has been completed.

Those who require support to live with illness, live independently, or to die well - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For those who require support to live with illness, live independently, or to die well we will build the following types of capabilities:

Community development

- Community engagement strategy that focuses on building communities and identifying local assets to support those with ill health and those who require support to live independently.
- Identification of existing community assets to engage further with people and communities to understand their needs and gaps in initiatives.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts needs.

Estates

- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access. This will include co-location of services accessed by this cohort of the population to reduce unnecessary travel and to promote access and self-management of needs where appropriate.

Workforce and culture

- Development of workforce 'passport' to allow those who work with this population cohort to move between organisations to share knowledge, experience and practice.
- Workforce development to create clarity across all system partners of how best to support this population of the cohort in the long term.

Programme management

- Define and embed a system-wide programme and project management capability to manage multi-agency projects individuals living with illness, including VCFS, health, care and wider partners. This provides an opportunity to understand where there may be duplication in the system as well as existing gaps.
- The same can be done for those who require support to live independently though this will require stronger link in to local communities.

Digital and technology

- Development of system-wide place strategy for utilising digital and technology in the provision of care for this population cohort.
- Development of system network, enabled digitally, to support clearer signposting to organisations that can provide for locally based community provision of support.

Intelligence

- Working with the VCFS to better understand the data and analytics captured for this population cohort. This will allow for greater clarity of the existing outcomes and needs of this cohort.
- Develop system interoperability to share information on this population cohort between organisations to provide more targeted support.

Devolution / alignment of incentives

- Ability to pool budgets and subsequently jointly fund initiatives and services for those requiring support to live independently.

Population group five – *the deprived or vulnerable population*

Definition:

Those people living in deprivation, or those who are vulnerable across Surrey. This includes children in care and care leavers. The aim is to focus on those where indicators suggest they may have been left behind in the past and improve their health outcomes.

The difference we're aiming to make:

Outcomes	Metrics for Measurement	Current Performance	Target Performance	10 Year Target Outcomes Impact: Financial Impact
Children and Young People who are deprived or vulnerable succeed academically	*School readiness at reception for children who receive free school meals*	31.0%	39.2%	To be added when the finance / activity modelling has been completed
	GCSEs achieved (5A-C) for children with free school meal status*	40.0%	42.5%	
	GCSEs achieved (5A-C) for children in care*	17.2%	23.9%	
People in deprived areas feel fulfilled in their employment	*NEET rate*	4.3%	3.3%	
	Unemployment rate	2.4%	1.8%	
People in deprived areas have a healthy weight and are active	Obesity rates	25.4%	22.0%	
Substance abuse in deprived areas is low	Excessive alcohol consumption rates	19.0%	18.0%	
	Smoking rates	26.0%	11.0%	
People live in adequate housing with access to services	Overcrowded housing	3.4%	2.1%	

Outcome metrics 'People with depression and anxiety are supported', 'No-one in Surrey feels isolated' and homelessness rates have not been modelled due to the availability of data.

The deprived or vulnerable population - examples of supporting initiatives

1. Targeted support for the vulnerable or deprived children and young people in Surrey

- The joint-establishment of 'link workers' to be based in local schools, nurseries and children's centres to **identify the children and young people who would benefit from a range of new opportunities in school, provided by community partners.**
- Partners are those local VCFS who provide a wide range of services (e.g. drug and alcohol abuse, sexual health and financial literacy) but can also include community based health and care providers.
- Where implemented elsewhere the following benefits were experienced;
  - **80% of children improved attainment, wellbeing and / or attendance in school after one year of establishment**; and
  - 85% engaged with the support to a high level.
- A link worker would be able to understand at a much more granular level **the root causes behind existing poor outcomes for children in Surrey living in deprivation or who are vulnerable,** and therefore be proactive in coordinating the necessary support to tackle the need.
- There is also the opportunity to consider how the **entire family of those children and young people** living in deprivation or who are vulnerable becomes part of the conversation, for example a link worker signposting to the effective services.

2a. Health and Housing MoU

- The establishment of a **strategic alliance between health and housing providers and commissioners** to collectively improve health outcomes which are a result of poor housing conditions.
- Through the acknowledgment of the profound impact housing has on health outcomes, a place-based approach can be developed between health and housing beginning with a clear MoU **aligning leadership across health and housing towards common goals** of improving the health and outcomes of the population living in deprivation.

2b. Housing First rollout across Surrey

- Implementation of a model of housing for the homeless whereby people are **provided with permanent housing and support to stay in this housing for a longer period of time**, reducing the need and cost of supported housing.
- The desired impact is **increasing the stability of housing for homeless people** resulting in improved health and wellbeing outcomes. Increasing stability is enabled by the targeted support from system-wide partners (e.g health support including mental health support, social care support, employment support etc.) which is coordinated by core owners of the programme.

Sources: http://westlondonzone.org/what-we-do/, http://westlondonzone.org/wp-content/uploads/2016/10/Executive-Summary-of-WLZ-Implementation-Study-1.pdf, file:///C:/Users/942858/Downloads/Nottinghamshire%20MoU.pdf, file:///C:/Users/942858/Downloads/Nottingham%20homes%20MoU.pdf, https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/housing-models-and-access/housing-first-feasibility-study-for-liverpool-city-region-2017/

Overall potential impact on priority areas and cohorts

Target Cohorts	Priority Areas: Healthy Lifestyles	Emotional Wellbeing	Fulfill Potential
General Population			
Deprived	Medium	High	High
People with SEND and LD			
Young and Adults Carers			
Living with illness & ill health			

*Potential Finance and Activity Impact of initiatives**

'Link Workers'	Housing First
£	£
X	X

* To be added when the finance / activity modelling has been completed.

The deprived or vulnerable population - building capabilities

In order to implement initiatives successfully, we will need to engage with all the necessary partners from health, social care and beyond, and put in place the right governance and infrastructure. For this group, the deprived or vulnerable population, we will build the following types of capabilities:

Community development

- Strong community development and support in those areas with higher deprived or vulnerable populations.
- Clearer understanding of networks and assets available to support this population cohort, and co-development of initiatives with those networks.

Clear governance

- Clarity on how the target outcomes and metrics for measurement will be reported and monitored for this population cohort, including accountability and decision-making responsibility.
- Further clarity developed on which system partners are responsible for what aspect of this population cohorts needs.

Estates

- Affordable housing strategy that redirects public sector estates resources to appropriate housing for this cohort.
- Public sector estates strategy that encourages community based, multi-service provision in welcoming environments, to promote access.

Workforce and culture

- Multi-agency case lead agreement that allows the appropriate agency to take the lead role or make required decision.
- Workforce develop to train all staff to recognise signs of vulnerability and feel confident in an appropriate response.

Programme management

- Embedded programme and project management support capable of managing cross-agency projects across the system for this cohort.
- Portfolio management evaluation of existing initiatives from across the system to understand areas of duplication and opportunities to scale up initiatives across a wider geography.

Digital and technology

- System interoperability which supports data sharing to better understand the breadth of needs of this cohort.
- Easy to access digital channels that make finding and accessing support simple and inviting.

Intelligence

- Strong data sharing between organisations and sectors to support a strong single view of individuals/families.
- Intelligent analytics to support accurate targeting of individuals and families who have higher risk factors.

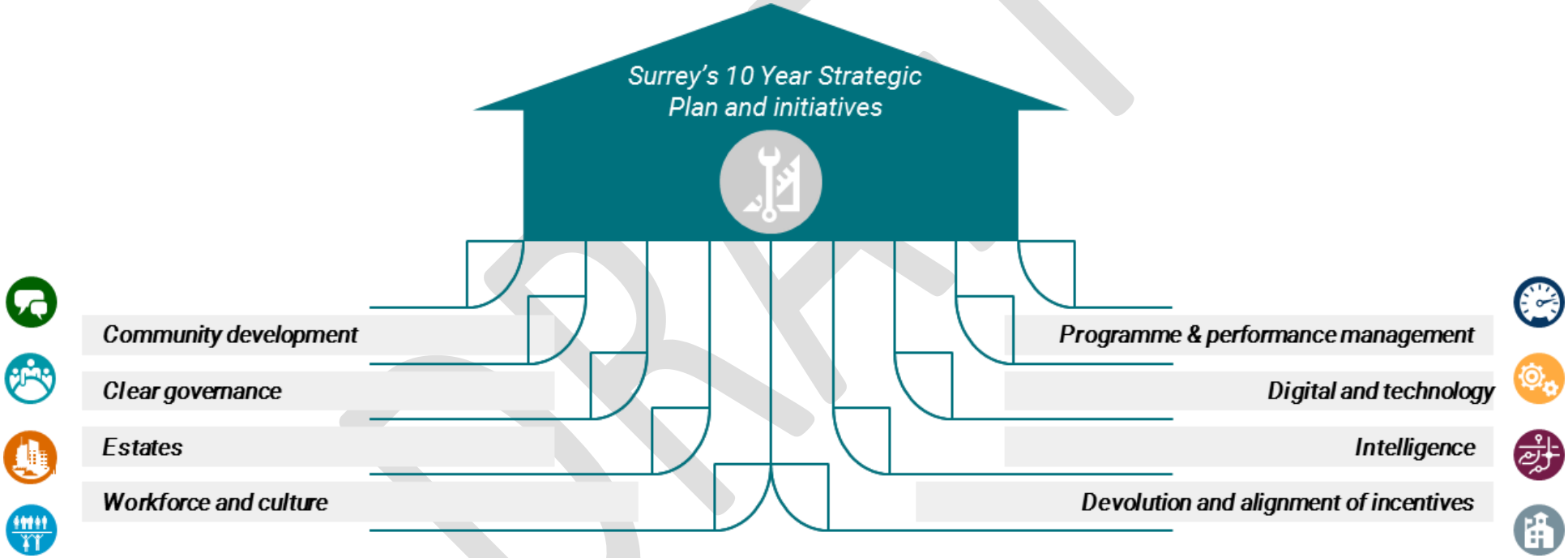
Devolution / alignment of incentives

- Ability to pool budgets and subsequently jointly fund initiatives and services for those with vulnerabilities or living in deprivation.

SYSTEM CAPABILITIES

Our target outcomes over the next 10 years give us a clear vision of what we want to achieve for our citizens and organisations in Surrey. It's also clear we need to work together in a different way and develop new capabilities if we are to meet these targets. Breaking down the barriers that might be preventing collaboration across the different parts of the Surrey system will be critical for success, and to driving real system change.

In addition to the specific capabilities we've highlight for each of the groups above, the diagram below describes the system-wide capabilities we are committed to developing and embedding. We recognise this will include some challenging decisions which must be taken by the partnership, through open and honest conversation, to allow the best outcomes to be achieved.



As we engaged partners to develop this plan, we identified a number of barriers that need to be addressed but also the desire to focus on building the necessary capabilities, particularly in digital and workforce to overcome these. That feedback has informed a number of areas that we will take forward. The next section of this strategy summarises these, with further detail included in Appendix Seven.

Community development

The co-development of communities is integral to delivering a 10 year plan across Surrey. We are committed to building clear channels for engaging local communities and residents and to support community development. Citizens require communication channels that are easy to access and use, with clear and consistent messages from Surrey partners. This needs to be a two-way dialogue between partners and citizens, but also within and between partners. This will support system decisions which are relevant and responsive to the needs of the population.

Areas of focus:

We will work to establish two-way feedback mechanisms between our organisations and local people, but also within organisations so information is more clearly communicated and responded to. This includes joining up existing community development and engagement activities (for example the existing work on Stronger Communities) to create a more consistent approach and decrease duplication.

Clear governance

We are putting in place decision-making that is simple, collaborative and clear, whilst being representative of all partners in Surrey. A refined governance process will hold the leadership across Surrey to account for delivering this plan and its outcomes. It will also replace current multiple and often overlapping meetings with a single decision-making forum. Challenges and priorities will be discussed and viewed holistically. Partners will be clear on the approval route for multi-partner decisions, with joint leadership for the strategic plan.

Areas of focus:

Aligning the focus and decision-making across the Surrey-wide system, which will include giving back time to senior leaders who attend multiple partnership meetings with duplicated remit and authority. This will include a detailed mapping of existing decision-making responsibilities to redefine a clearer and streamlined model, with clear accountabilities and terms of reference. This should be linked to the system architecture and assurance work currently ongoing within the Surrey Heartlands Integrated Care System. Ultimately the Health & Wellbeing Board will be responsible for the delivery of this 10 year plan, and therefore this framework will need to link to the membership and responsibilities of this board. It will also need to remain conscious of the various levels of governance that sit below the Health & Wellbeing Board, such as local Health and Wellbeing Boards across the Districts and Boroughs.

Estates

We will establish one consistent estates and assets approach across Surrey which focuses on:

- using a one-Surrey estates ethos to consolidate collective estates across the patch;
- multi-use, accessible, community based estates for operational uses; and
- delivering sustainable housing, supported accommodation and income-driving solutions across the county.

All partners are signed-up to a unified approach, and the appropriate decision-making powers are given to the relevant group charged with driving this through for Surrey.

Areas of focus:

Bringing together all the estates and assets transformation work currently ongoing across Surrey beneath one system-wide umbrella; Surrey County Council has already begun to combine their estates workstream with Surrey Heartlands' Estates programme. An exercise to map all estates across all partners in Surrey will be needed to understand the baseline position - Surrey County Council has already started some of this work with the Districts and Boroughs. This programme of work can then drive co-development of a single Estates and Assets Strategy for Surrey with all partners. Critically, this work will need to involve all key decision-makers (e.g. NHS Property Services at a national level; Districts and Boroughs etc).

Workforce and culture

Surrey requires a modern and radical workforce approach that will create and develop a future workforce equipped to manage the demands of the future. It will also need to work collaboratively to deliver the priorities set out in this plan. This requires a strong approach across all partners that develops the right culture, values, behaviours, skills, training, and leadership. Other areas such as adequate housing and transport for local workers also needs to be considered.

Areas of focus:

To move towards a joined up and multi-skilled 'Surrey workforce' for the public sector which is able to work collaboratively regardless of the specific employer. This could be enabled by joining up the existing workforce, and/or creating a 'workforce passport' which allows employees to share knowledge and experiences across the system. A Surrey public sector skills academy could help develop and deliver training, building consistent values, behaviours and culture across all employees and promote cross-disciplinary learning. Any approach should be co-developed with all partners to form a Surrey workforce strategy and approach.

Programme and performance management

We are establishing a programme management capability which can manage multi-partner programmes and delivery effectively across Surrey, including effective navigation of existing system work (across the STPs/ ICSs, ICPs, Surrey County Council transformation programme etc.) Ability to monitor performance of delivery of the 10 year plan: tracking metrics, monitoring delivery from individual partners, convening partners when required to focus on underperforming areas. Ability to coordinate resources across Surrey programmes, recognise and manage interdependencies, and support interactions with other regional systems as required.

Areas of focus:

Establish a partnership programme management office (PMO) with the clear remit and responsibilities for delivery of the 10 year plan. This could be hosted by any of the existing PMOs across Surrey, or we could consider consolidating the multiple PMOs into fewer/one office to manage all programmes. This would have clear accountabilities to the decision-making group for the 10 year plan; including regular progress reports, escalation of risks and barriers for resolution etc. All partners would be aware of the office and actively feed-in progress, risks and opportunities. The use of a technology platform to enable collaboration should also be considered so project documents could be consolidated - this is particularly important given that the programme will be multi-agency.

Digital and technology

We will prioritise the work to ensure our information systems work together within and across organisational boundaries, for more efficient transfer of knowledge and information sharing; greater collaboration; and better visibility and transparency over performance data. There must be a baseline level of digital and technological maturity across the partnership - setting the foundations for further development of technology opportunities e.g. technology that allows for better and faster engagement with citizens, technology for collaboration between partners. The baseline requirement needs to be defined and established, with investment made in areas with significant gaps. A strong digital and technology approach is also key to supporting how we deliver intelligence (data and analytics) across the county.

Areas of focus:

Mapping the current digital maturity across all Surrey partners to identify gaps or barriers to in how our information systems work together (system interoperability), building on work being done by Surrey Heartlands. Understand the specific areas that need investment or a change in digital tools being used. Creating a clear and level baseline of digital maturity would be enabled by understanding those gaps, but also understanding what the long-term goal or digital ambition of the Surrey-wide system is for working with its population to improve outcomes.

Intelligence

We will build data sharing and intelligent analytics which underpin effective decision-making and provide clarity on how the system is performing. This should embed the practice of data sharing across all partners, who understand the benefit and need for effective sharing and maintaining quality information and data. It also includes an intelligence and predictive analytics capability that understands risk factors and can identify potentially high-risk individuals and groups who should be targeted for prevention. Lastly, it would also easily track the metrics required to monitor progress against outcomes in the 10 year plan.

Areas of focus:

Work has already been done to start building an analytics infrastructure across the Surrey Heartlands system that provides data-driven insights - the Surrey Office of Data Analytics (SODA). This is a virtual way of working to promote use and value of data currently held across different parts of the system. SODA will also provide a resource that can make use of new shared data infrastructure when it becomes available. This initiative, if expanded to include all Surrey partners, would effectively support the delivery of the 10 year plan, although the entire system needs to use the capability to maintain its relevance and **maximise impact.**

Devolution and alignment of incentives

Devolution allows freedoms and flexibilities so the Surrey system can align incentives across partners and eliminate financial and performance barriers to collaboration. More innovative payment mechanisms are needed to align partners' incentives to invest in prevention, influencing/signposting, and early support; and to enable partners to make operational decisions which prioritise citizen outcomes. Devolution provides an opportunity to seek the relevant powers and freedoms to do this, although devolution only covers part of the Surrey geography and partners.

Areas of focus:

Establishing a commercial model which links payments to achievement of target outcomes, including a risk and gain share which incentivises organisations to focus on prevention for the long-term benefit of Surrey and its population. Pooled budgets, as an example of a risk-sharing arrangement, would allow for the breakdown of barriers between organisations and a mechanism through which to jointly hold partners to account for collective delivery against outcomes.

In addition, the Devolution deal for Surrey Heartlands affords the region some power to negotiate additional freedoms or requests from central government that could benefit the whole of Surrey. A clear review and assessment of what may be required and potentially requested would need to be completed and agreed by Surrey's senior leadership before entering into negotiations with government. This may include requests for freedoms or deviations from the national policy in areas such as payment by results (PbR) etc.

FURTHER INFORMATION

Further information about how the Joint Health and Wellbeing Strategy has been developed can be found in the suite of appendices supporting this strategy document.

Further information about health and wellbeing in Surrey can be found on the healthy Surrey website https://www.healthysurrey.org.uk/

For any other questions about the Joint Health and Wellbeing Strategy please email us at healthandwellbeing@surreycc.gov.uk

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