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

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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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