Hampshire County Council

NOTICE OF MEETING

Meeting	Health and Wellbeing Board
Date and Time	Thursday, 2nd March, 2023 at 10.00 am
Place	Ashburton Hall, Elizabeth II Court, The Castle, Winchester
Enquiries to	members.services@hants.gov.uk

Carolyn Williamson FCPFA
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website and available for repeat viewing, it may also be recorded and filmed by the press and public. Filming or recording is only permitted in the meeting room whilst the meeting is taking place so must stop when the meeting is either adjourned or closed. Filming is not permitted elsewhere in the building at any time. Please see the Filming Protocol available on the County Council's website.

AGENDA

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence received.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Personal Interest in a matter being considered at the meeting should consider, having regard to Part 5, Paragraph 4 of the Code, whether such interest should be declared, and having regard to Part 5, Paragraph 5 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 8)

To confirm the minutes of the previous meeting held on 15 December 2022.

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. INTEGRATED CARE STRATEGY (Pages 9 - 108)

To review and note the Integrated Care Strategy documents for both the Hampshire and Isle of Wight Integrated Care System and for the Frimley Integrated Care System.

7. AGEING WELL UPDATE - THEME FOCUS (Pages 109 - 126)

To review ongoing work as part of the Ageing Well strand of the Health and Wellbeing Strategy.

8. SMOKEFREE HAMPSHIRE 2030 - ACHIEVING A SMOKEFREE GENERATION FOR HAMPSHIRE BY 2030 (Pages 127 - 142)

To provide an update to the Health and Wellbeing Board on the refreshed Tobacco Control Strategy for Hampshire.

9. FORWARD PLAN (Pages 143 - 148)

To consider the Forward Plan for topics at future meetings of the Board.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

AT A MEETING of the Health and Wellbeing Board of HAMPSHIRE COUNTY COUNCIL held at The Castle, Winchester on Thursday, 15th December, 2022

Chairman:
* Councillor Liz Fairhurst

Vice Chairman:
* Dr Matt Nisbet

* Councillor Roz Chadd	* Ron Shields
* Graham Allen	Alex Whitfield
* Simon Bryant	David Radbourne
Steve Crocker	Ann Smith
* Ros Hartley	* Jason Avery
Sam Burrows	Donna Jones
Emma Boswell	* Clare Jenkins
* Dr Gareth Robinson	* Suzanne Smith
* Gill Kneller	* Councillor Michael Hope
Councillor Anne Crampton	* Terry Norton
* Julie Amies	

*Present

56. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Anne Crampton.

57. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Personal interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 5 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

58. **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 6 October 2022 were reviewed and agreed.

59. **DEPUTATIONS**

There were no deputations.

60. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman and Board Members expressed their condolences to the Hampshire family of the child who had died as a result of a Strep A infection.

The Chairman noted that the terms of reference for the independent review of integrated care systems led by Rt Hon Patricia Hewitt had been published online.

With regards to the Better Care Fund, the Chairman made members aware of the £500million Winter Fund which had been announced to support discharges from the acute hospitals. The Chairman noted the funding allocated to the Hampshire NHS ICB's totalled £13.34millon with the Hampshire Place share of the £13.34million equating to £8.14million. Furthermore, members heard that the Hampshire County Council share of the Local Authority allocation had been confirmed as £3.9million. The Chairman noted that she would formally sign off the BCF submission on behalf of the Health and Wellbeing Board.

The Chairman announced that the regular communications from the Hampshire Place Board would be distributed prior to each Health and Wellbeing Board meeting and that the annual report of the Place Board would also be presented annually as part of the Better Care Fund reporting cycle.

All members were also encouraged to attend the Hampshire Place Assembly event which was taking place after the Board meeting.

61. **ELECTION OF VICE CHAIRMAN AND BOARD SPONSOR FOR LIVING WELL**

The Chairman called for nominations. Graham Allen nominated Matt Nisbet. Councillor Roz Chadd seconded this nomination. There were no other nominations and Dr Nisbet was duly elected as Vice Chairman and also agreed to become the Living Well Sponsor for the Board.

62. **STRATEGIC LEADERSHIP: TERMS OF REFERENCE REVIEW**

The Board considered the report regarding their Terms of Reference and agreed recommendations as below.

RESOLVED:

i) That a section be added to the existing Health and Wellbeing Board Terms of Reference as new paragraphs at 9.12 and 9.13 as below:

'To receive updates and reports from the Hampshire Health and Social Care Place Board including all matters pertaining to the Better Care Fund, delivery of Better Care Fund savings and governance of the Better Care Fund plan.'

'That the Health and Wellbeing Board contributes to the Integrated Care Partnership Strategy for both the Hampshire and Isle of Wight Integrated Care Board and the Frimley Integrated Care Board.'

ii) That the Hampshire Health and Wellbeing Board review Paragraph 9 of the existing Terms of Reference and propose any suggested changes to this Paragraph to Cabinet and County Council for their consideration.

63. **HAMPSHIRE HEALTH AND WELLBEING STRATEGY - HEALTHIER COMMUNITIES**

The Board considered the agenda item providing an update on the priorities and progress of the Healthier Communities strand of the Hampshire Health and Wellbeing Strategy.

Members' attention was drawn in particular to work being conducted in Andover via a multi-agency approach to address health and wellbeing inequalities. As part of this, the Board heard of proposals to recruit a community health worker to help support the relationships with Primary Care Networks and other health bodies and structures via the Hampshire and Isle of Wight ICB. It was noted that a similar role was being recruited to at the Frimley ICB.

Members also noted some other projects which were underway to support the Healthier Communities strand of the Health and Wellbeing Strategy and some example case studies of partnership working from across the county.

RESOLVED:

That the Health and Wellbeing Board note and support the good practice examples of work going on across Hampshire to develop healthier communities, along with the value of partnership working in this area to reduce health inequalities in Hampshire.

64. **STARTING WELL: HOUSEHOLD SUPPORT FUND**

The Board reviewed the agenda item outlining the approach for the allocation of the Department for Work and Pensions (DWP) Household Support Fund Extension across Hampshire and also noted details of a wide range of schemes available to support households during the winter.

Board Members were strongly encouraged to share the resources with their organisations and communities to help promote the schemes and help support residents.

RESOLVED:

That the Health and Wellbeing Board:

i) Note the wide range of schemes available to support vulnerable households during the winter.

ii) Share details of the offer and signpost to households who may benefit from the initiatives in place.
iii) Encourage local organisations to apply for community grants.
iv) Encourage households to use their local community pantry.

65. **STRATEGIC LEADERSHIP: HAMPSHIRE PLACE ASSEMBLY**

The Board considered the agenda item setting out the governance for the Hampshire Place Assembly and agreed recommendations as below.

RESOLVED:

That the Health and Wellbeing Board:
i) Endorse the purpose and priorities of the Hampshire Place Assembly.
ii) Members attend and engage with the forum to discuss health and wellbeing at a Hampshire place level connecting the priorities identified with other relevant forums.

66. **STRATEGIC LEADERSHIP: INTEGRATED CARE STRATEGY DEVELOPMENT**

The Board considered the agenda item providing an update on the development of the Integrated Care Strategies for both Hampshire and Isle of Wight Integrated Care System and Frimley Integrated Care System.

RESOLVED:

That the Health and Wellbeing Board:

i) Receive the report and note the priorities identified in both strategies.
ii) Consider its role in helping to deliver the emerging priorities across both ICS's.

67. **FORWARD PLAN**

RESOLVED:

The Board agreed to add an item related to Children and Young People's Physical Activity Levels in the 2021-22 academic year and that this would be linked with some reporting around Healthy Weight Management for the June 2023 meeting.

The Board received and noted the remainder of the Forward Plan.

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Wellbeing Board
Date:	2 March 2023
Title:	Integrated Care Strategy Documents
Report From:	Ros Hartley, Director of Partnerships, Hampshire & Isle of Wight ICB Sam Burrows, Chief Transformation & Digital Officer, Frimley ICB

Contact name: Ros Hartley & Sam Burrows

Email: ros.hartley1@nhs.net
sam.burrows3@nhs.net

Purpose of this Report

1. This paper introduces the published Integrated Care Strategy for Hampshire and the Isle of Wight ICS as well as the draft strategy for Frimley ICS which is due to be ratified by the Integrated care Partnership for publication in March

2. A summary of the key themes for each strategy has been done to assist the board in understanding where the similarities and differences are between the two documents

3. The Board and the Place Assembly along with other forums will continue to work on turning the priorities into delivery and making sure residents are involved with co-producing the solutions

Recommendation(s)

That the Hampshire Health and Wellbeing Board:

4. Receive the reports and note the priorities identified in the two strategies.

5. Consider its role in helping to deliver the emerging priorities across both ICS's

Executive Summary

6. Hampshire County Council is part of the Hampshire and Isle of Wight and Frimley Integrated Care Systems, both of which were established in July 2022 as part of the new Health and Social Care Act 2022. Both systems are composed of two new statutory health and care components; an Integrated Care Board and an Integrated Care Partnership.

7. The primary purpose of the Integrated Care Partnership is to develop the Integrated Care Strategy for the Integrated Care System and to oversee and ensure the delivery of this strategy. Both strategies have been previously socialised at the Health & Wellbeing Board throughout their development and the final versions now form part of this report.

8. The purpose each Integrated Care Strategy is to describe the ambitions and priorities across each system building on the work of the Local Health and Wellbeing Boards, which should not duplicate, but set priorities where joint working, beyond place is most helpful.

9. The Hampshire Place Assembly will continue to provide a forum for a wide range of colleagues from many organisations to have a discussion about the strategic priorities from both Hampshire and the Isle of Wight ICS and Frimley ICS to make it real for the residents of Hampshire.

Key priorities for each Strategy

Frimley - Strategic Ambitions

10. The 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.

11. The six 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

12. Each of the Strategic Ambitions will focus on a discrete number of headline priorities in the 3-5 years ahead

Hampshire and Isle of Wight Strategic Priorities

13. The aim of the work together as a partnership is to improve the health, happiness, wealth and wellbeing of the local population. In doing so, over the medium to longer term, this will:

• Reduce the demand for health and care services

• Enable us to further improve the quality of service we provide

• Relieve pressure on the people who work in our organisations

• Enable us to live within our financial means

14. Five priority areas emerged from initial assessment of data and understanding insights from people, communities and colleagues:
    - Children and Young people
    - Mental Wellbeing
    - Good health and proactive care
    - Our People (Workforce)
    - Digital solutions, data and insight

15. The strategy identifies a small number of priority areas where there is an opportunity to add value across the four places, recognising that most of the work undertaken to tackle health inequalities, improve health outcomes and service delivery, and contribute to social and economic development is delivered in local places.

Conclusions

16. Both strategies have been developed in partnership with local authorities; the Joint Strategic Needs Assessment and Health and Wellbeing Strategy for Hampshire which have been used to inform the case for change and priorities.

17. Both strategies have been developed with a broad range of stakeholders and set out the aspiration to unlock the benefits of greater partnership working and using the collective resources more effectively to improve the health of the population.

18. Both strategies place an emphasis on the importance of working better with children and families, as well as supporting people to live healthy lives with an emphasis on preventative interventions to reduce the need for health and care services in the long term.

19. Both systems recognise the need to review their workforce models to build capacity and ensure the right skills and capabilities are there for the future. The importance of investing in digital solutions and sharing capacity across the partnerships also come through as themes

20. Both strategies build on and support the work ongoing at a Hampshire place level. To ensure the effective delivery of the strategy, it is recognised that partnership working with the Health and Wellbeing Board will be vital.

21. Recently released non-statutory guidance sets out the roles and duties of H&WBBs and clarifies their purpose within the new system architecture. **Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)**

22. It recommends that H&WBBs consider the integrated care strategies when preparing their own strategy to ensure that they are complementary.

23. Along with other local leaders, H&WBBs will continue to lead action at place level to improve people's lives and remain responsible for promoting greater integration and partnership between the NHS, public health and local government.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Other Significant Links

Direct links to specific legislation or Government Directives	
Title	Date
Integrated Care Systems: design framework	**June 2021**
Thriving places Guidance on the development of placebased partnerships as part of statutory integrated care systems	**September 2021**
Health and social care integration: joining up care for people, places and populations	**February 2022**
Health & Wellbeing Board Guidance	**November 2022**

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

At this stage, an equalities impact assessment is not relevant because the item for discussion is an update for discussion and noting.

HAMPSHIRE AND ISLE OF WIGHT

INTEGRATED CARE STRATEGY

December 2022

This document sets out our interim strategy with five agreed priority areas to drive forward the next phase of our work together. It will be further reviewed, developed and refined through 2023.

This interim strategy has been jointly developed by partners and stakeholders from across Hampshire and Isle of Wight

The integrated care partnership is responsible for setting the strategy for health and care in Hampshire and Isle of Wight to meet local healthcare, social care and public health needs. We will continue to work with new and existing partners to further develop and deliver our strategy. This interim strategy has been jointly developed by partners and stakeholders, including:

Contents

To jump to individual sections, please hover over the section title above, then Ctrl+ click to follow the link

Foreword

Building a better future together

The Hampshire and Isle of Wight integrated care partnership is committed to improving the health, happiness, wealth and wellbeing of the population. Building on our strong track record of working together as partners and with local people, we look to the future with great optimism. We are united in our work with people and communities, creating a society in which every individual can thrive throughout the course of their life, from birth to old age. Our mission is to deal with the pressures and challenges of today, seize opportunities and together build a better future.

Through working closely with local communities, we know that people want improved health and wellbeing, as well as:

- More choice and control over their own health and wellbeing
- Easier access to services and resources, and when they need it – the right support and care, in the right place, and the right conversations, at the right time.

This strategy focuses on the some of the wider factors which impact on our lives and health more broadly, and drive our need for support, health and care services. In 'healthcare' terms, we know that getting appointments with a dentist, GP and access to emergency care is a significant concern. There are short and long term things we are doing to address this. The healthcare system's 'joint forward plan' due in April 2023, will focus on the more targeted actions we need to take to improve access and the effectiveness of our healthcare services.

Providing better joined up services in Hampshire and Isle of Wight

This strategy is ambitious; set against a challenging backdrop. Local people are experiencing widening inequalities, varied access to services and in some cases, poor experiences of health and care support. Covid-19 and increases to the cost of living have placed additional pressure on households and individuals, voluntary, community and public sector resources including education, housing, fire, police, social care and health services. Demand for health services is increasing more quickly than funding and more quickly than we can recruit and train staff. Funding levels in social care have been repeatedly cut for over a decade, whilst care demands have continued to rise. The November 2022 Autumn Statement is positive for health and care finances but challenges remain. Rising inflation, increasing energy prices and government fiscal policy place additional pressure on already overstretched services.

We know too, that staff across our various organisations continue to work incredibly hard under continued strain and that the impact of the pandemic is far from over. Recruiting, developing, supporting and retaining staff across all partner organisations is a core strategic priority for us as a partnership.

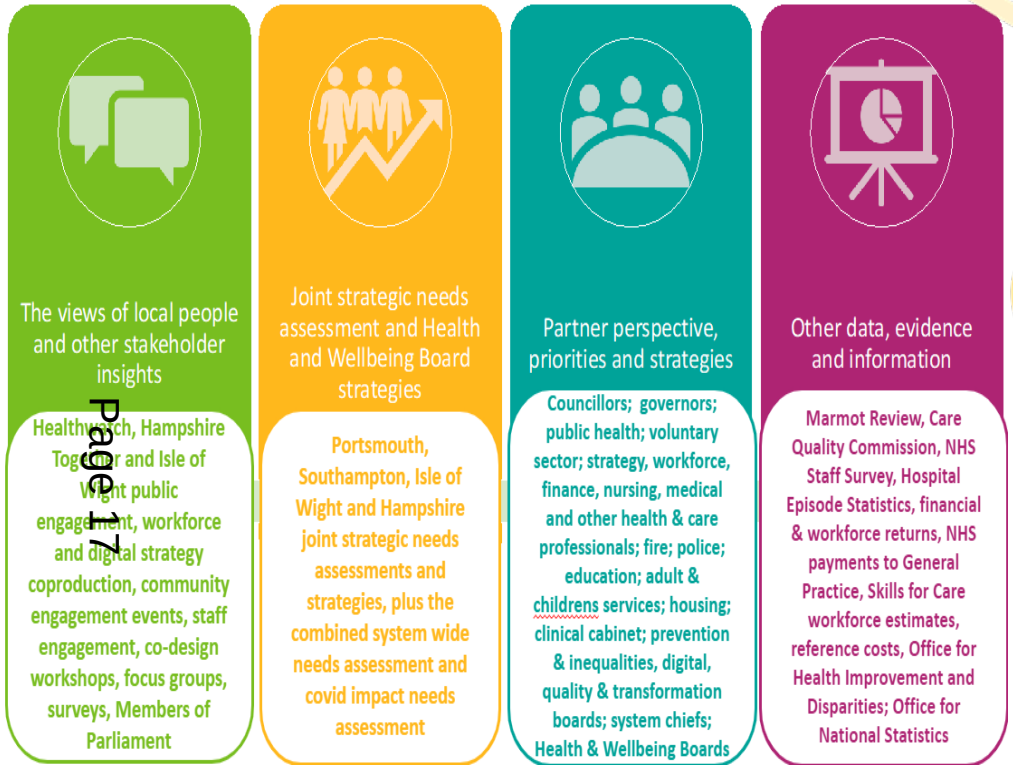
It is vital that we work on our priorities together to improve health and wellbeing

We are embracing the opportunity to better coordinate our work together. We are committed to working differently, and more closely together, to explore new innovations and options to make best use of the collective resources available. This interim strategy is a strong first step and will continue to evolve and build momentum over time.

We would like to thank the huge number of colleagues and members of our local communities for their input in shaping this interim strategy and their ongoing commitment, input and support.

Developing our strategy

Information and people involved in shaping this strategy



1. **We reviewed the available data and evidence** (Hampshire and Isle of Wight Joint Strategic Need Assessments, Health and Wellbeing strategies, system diagnostics)

2. **We worked with our local communities and across partner organisations to understand their perspectives and priorities** – we had multiple conversations with the integrated care partnership and in other focus groups and meetings with colleagues to inform our themes for initial focus as a partnership.

3. **We identified five priority areas for initial focus:** children and young people; mental wellbeing; prevention of ill health and promotion of healthy lifestyles; workforce; digital and data. We continued working with all partners to identify data, insights and evidence around each of these themes.

4. We held a workshop on 28 September 2022 in which members of the public and colleagues **reviewed the evidence** under each theme and **created a longlist** of ideas for our joint work as a partnership on our five priority areas. Following the workshop we continued to work with all partners to flesh out these ideas.

5. We agreed the **priority areas** for our strategy. These are the areas around which we will focus our early work together as a new partnership. We have each committed to working together to seize opportunities to enhance our existing work in these areas. It is important to note that this strategy does not set out all the work happening across Hampshire and Isle of Wight. Furthermore, we will review our strategy regularly as a partnership to ensure our priority areas of focus are relevant and that we make continuous progress against them. This will include working with health and wellbeing boards to further develop, implement and refresh our partnership strategy.

This strategy:

- ✓ builds on **work already completed** (including the joint strategic needs assessments and health and wellbeing strategies)
- ✓ focuses on **better integration of health, social care, wider public sector and voluntary sector services**
- ✓ sets priorities for joint working where **collective working (beyond local places) is most helpful**
- ✓ is **co-developed** with a wide range of partners
- ✓ has regard to the NHS Mandate 2022-23
- ✓ will **be updated regularly** to reflect the changing needs of local people and opportunities to work even more effectively together

This interim strategy provides a strategic direction and key commitments at a headline level. It is not a detailed operational plan. Our local authorities and the NHS are required to give full attention to this interim strategy in considering how we plan, commission and deliver services. For example, the integrated care board and NHS partners will take into account this interim strategy when developing more detailed delivery plans to support the national requirement for a five-year NHS 'joint forward plan' by April 2023.

To read the joint strategic needs assessments, please visit:

Hampshire: Joint Strategic Needs Assessment (JSNA) | Health and social care | Hampshire County Council (hants.gov.uk) **Isle of Wight**: JSNA - Overview - Service Details (iow.gov.uk)

Southampton: Joint Strategic Needs Assessment (JSNA) (southampton.gov.uk) **Portsmouth**: Joint strategic needs assessment - Portsmouth City Council

Selecting our priorities as a partnership

We codeveloped the following strategy design principles to support us as a partnership, in deciding which priorities we should include in our strategy:

- ✓ People and communities have told us are important to them
- ✓ Address the root causes of what affects people's health and quality of life
- ✓ Address health inequalities
- ✓ Address at least one of the following points:
  - Making care and services more joined up for people
  - Making it easier for people to access the services they need
  - Giving people more choice and control over the way their care is planned and delivered
- ✓ Affects more than one geographical area (i.e. place) and warrants a system-wide focus. (If the priority area only affects one place then it is better sitting in a local health and wellbeing strategy)
- ✓ Are supported by a strong, evidence-based case for change – for example there are currently poor outcomes in this area
- ✓ Need all system partners to work together to tackle them and make best use of our combined capacity and capabilities
- ✓ Are recognisable and relevant to all system partners and support existing strategies
- ✓ Are within our gift as a partnership to impact.

The intended impact of our strategy

Ultimately, the aim of our work together as a partnership is to improve the health, happiness, wealth and wellbeing of the local population.

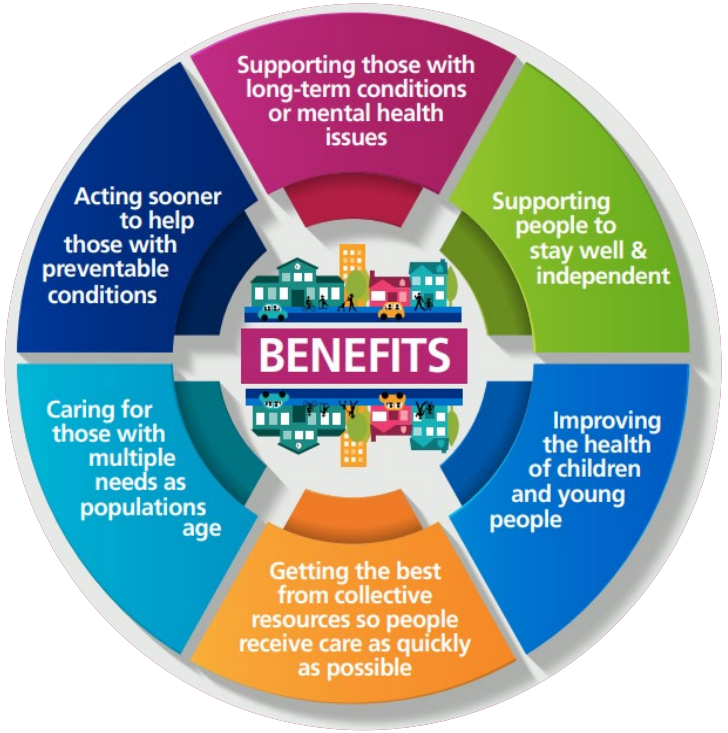
In doing so, over the medium to longer term, this will:

- Reduce the demand for health and care services
- Enable us to further improve the quality of service we provide
- Relieve pressure on the people who work in our organisations
- Enable us to live within our financial means

Alongside our work as a whole system partnership, various partners will continue to work together to do all they can to meet the health and care needs of local people in increasingly effective ways. This includes:

- Partnerships in each of our places, ie: Hampshire, Southampton, Isle of Wight, Portsmouth and at neighbourhood level;
- Partnerships working with people with very specific needs, for example around housing;
- Collaboration within 'sectors', eg: primary care, acute hospital trusts and the voluntary and community organisations

In combination, our efforts will deliver the benefits shown right.



Hampshire and Isle of Wight

OUR STRATEGY ON A PAGE

OUR PRIORITIES AND KEY AREAS OF FOCUS:

POPULATION OF 1.9M:

- Varied demographics
- Areas of deprivation
- Variation in life expectancy
- Strong partnership working to seize opportunities

Children and young people

Focus on the "best start in life" for every child in the first 1000 days of their life

Improve access and mental health outcomes for children and adolescent mental health services

Work with schools and other key partners on prevention and early intervention

Continue and develop our trauma-informed approach

Co-locate services to enable a family-based approach

Further develop a joint children's digital strategy

Mental wellbeing

Better connect people to avoid loneliness and social isolation

Promote emotional wellbeing and prevent psychological harm

Improve mental health and emotional resilience for children and young people

Focused work to prevent suicide

Improve access to bereavement support

Address inequalities in access and services

Support the mental health and wellbeing of our staff.

Good health and proactive care

Improve social connectedness

Provide support in community settings for healthy behaviours and mental wellbeing

Ensure equal importance is given to mental wellbeing and physical health

Provide proactive, integrated care for people with complex needs

Minimise potential health and wellbeing impact of cost of living pressures

Support healthy ageing and people living with the impact of ageing

Combine resources around groups of greatest need

Our people (workforce)

Evolve our workforce models and building capacity to meet demand

Ensure the availability of the right skills and capabilities

Ensure people who provide services are well supported and feel valued

Digital solutions, data and insights

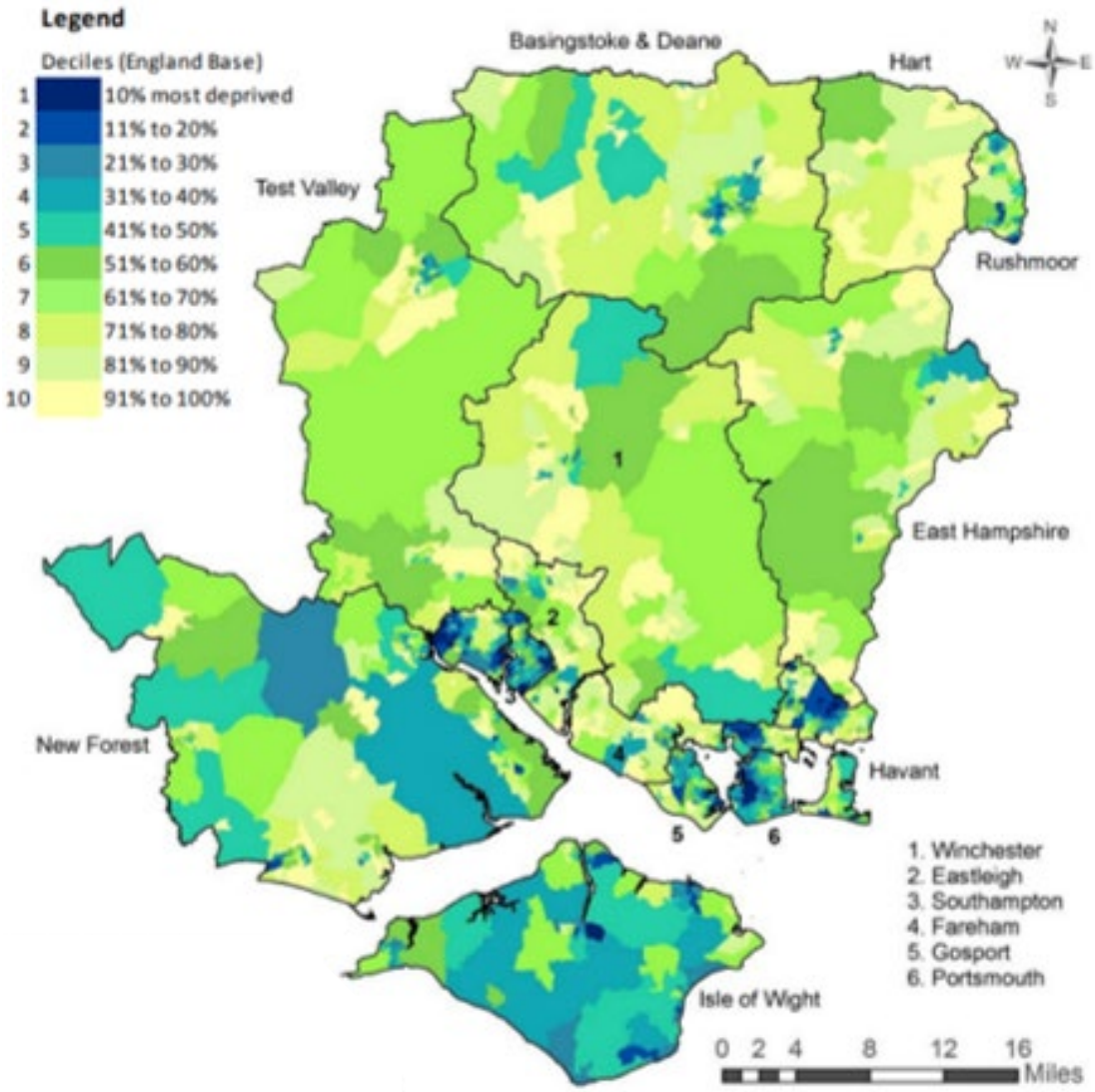
Empower people to use digital solutions

Support our workforce

Improve how we share information

Continue to improve our digital solutions

Context


Legend
Deciles (England Base)
1 10% most deprived
2 11% to 20%
3 21% to 30%
4 31% to 40%
5 41% to 50%
6 51% to 60%
7 61% to 70%
8 71% to 80%
9 81% to 90%
10 91% to 100%
Basingstoke & Deane
Hart
Test Valley
Rushmoor
East Hampshire
New Forest
Havant
Isle of Wight
1. Winchester
2. Eastleigh
3. Southampton
4. Fareham
5. Gosport
6. Portsmouth
0 2 4 8 12 16
Miles

The population we serve

The Hampshire and Isle of Wight integrated care system is the 10th largest of the 42 systems across England. Our four places – Hampshire, Portsmouth, Southampton and Isle of Wight - are the foundation of our system.

Overall, our population is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In urban areas such as Southampton, Portsmouth, and north-east Hampshire, the population is more ethnically diverse compared to the rest of the area (overall 93.8% white). There are also higher levels of deprivation and mental health vulnerability in these areas. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone. We also have coastal communities; 92.7% of the Island's population are resident in areas defined as coastal. These areas have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas.

In Hampshire and Isle of Wight, healthy life expectancy has decreased in most areas, meaning people are living more of their lives in poor health. This is particularly the case for people living in the most deprived areas. Smoking, poor diet, physical inactivity, obesity and harmful alcohol use remain leading health risks, resulting in preventable ill health.

Health Inequalities

Health, as well as people's experience of public services, vary depending on where a person is born and lives as an adult, their level of income and education and factors such as ethnicity, gender, age and sexuality. This is known as experiencing **health inequalities**; addressing these inequalities in Hampshire and Isle of Wight is a priority that runs throughout this strategy. Some people and communities experience significantly poorer **access, outcomes and life expectancy** than the rest of our population. In Hampshire and Isle of Wight we see:

- Higher levels of emergency care compared to the rest of England, especially in more deprived areas, where access to primary care, outpatient and planned care are lower.
- Deaths from cancer, circulatory and respiratory diseases are the greatest causes of the differences in life expectancy between the most and least deprived. More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions.
- A boy born in our most deprived areas will live on average between 6.1 years to 9.1 years less compared to a boy born in our least deprived area, and for a girl, between 2.3 years to 5.5 years less.
- Covid-19 has created additional health and social care needs and disproportionately impacted people living in more deprived areas, people with learning disabilities, older people, men, some ethnic minority groups, people living in densely populated areas, people working in certain occupations and people with existing conditions.
- Premature mortality in people with severe mental illness is higher than the national average on the Isle of Wight, Southampton and Portsmouth.

The issues that affect our health and wellbeing

People are dying due to preventable and avoidable ill health and there are wide inequalities in life expectancy. Almost every aspect of our lives – our jobs, homes, access to education, public transport and whether we experience poor attachment in early years, trauma as a result of adverse childhood experiences, poverty, racism or wider discrimination – impacts our health and, ultimately, how long we will live. These factors are often referred to as **the wider determinants of health**.

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Long term conditions: Around 30 per cent of all people with a long-term physical health condition also have a mental health problem with a higher proportion reporting high levels of anxiety

Housing: Those in rented accommodation are more likely to feel lonely often, especially in 16–24-year-old population groups

Health behaviours: Adults with depression are twice as likely to smoke as adults without depression. People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily.

Social connectiveness: Those with an underlying health condition more likely to feel lonely often – especially in the younger 16–24-year-old population groups

The impact of deprivation

On average, people in the more deprived areas of Hampshire and Isle of Wight live a shorter life than those in the least deprived areas (**3 years less for men and 2.8 years for women**). They are also more likely to spend more of their life in poor health. Portsmouth and Southampton see greater levels of deprivation, ranking 57 and 55 out of 317 local authorities in England (where a ranking of 1 = the local authority with the highest level of deprivation).

Hampshire is among the least deprived authorities although there are areas that fall within the most deprived areas in the country.
10% of children in Hampshire aged 0 to 15 years are living in income deprived families, and 9% of residents aged 60 or over experience income deprivation

Isle of Wight is the 80th most deprived authority in England. 92.7% of the population are resident in areas defined as coastal, which have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas (Chief Medical Officer's Report, 2021).Just over half the population of the Island lives in area which are in the three deciles of highest deprivation.

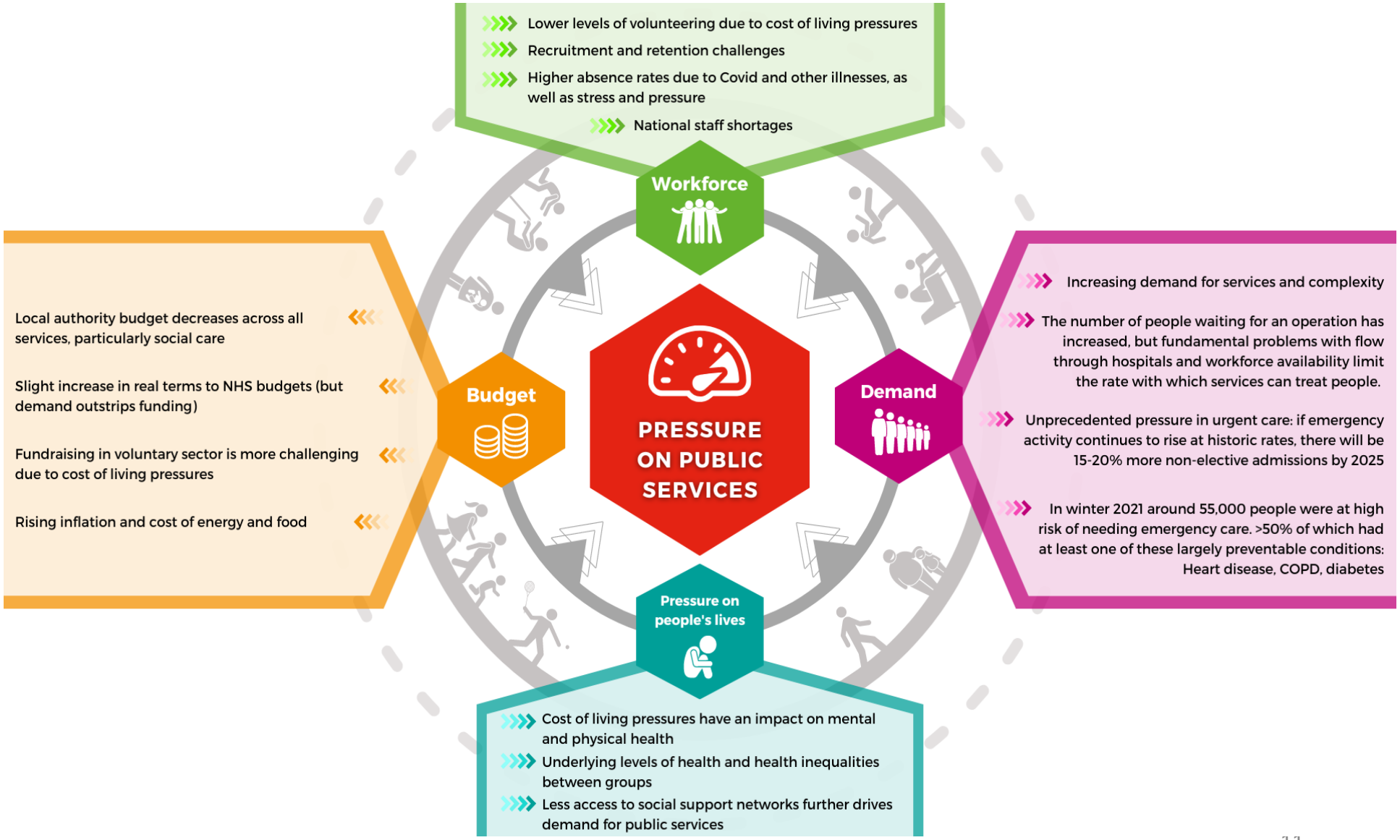
Portsmouth is ranked 57th most deprived authority in England. 13% of Portsmouth's population live in the 10% most deprived areas nationally, and over 60% are in the most deprived two quintiles.
25% of households in Portsmouth are in relative poverty. In 2019/20 17% of children were in absolute low-income families (before housing costs). This varies from 29% of children in the most deprived ward to 7% of children in the least deprived ward.

Southampton is ranked 55th most deprived authority in England. 28% of Southampton's population live in neighbourhoods within the 20% most deprived areas nationally.

The challenging environment in which services are operating

Our strategy is set in the context of an increasingly difficult environment for all partner organisations. Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This strategy is not about simply doing more, it is about taking a radically different approach.

Meeting these challenges requires looking in new ways at the workforce we have, including new staffing models and the ability for staff to create meaningful career paths across organisations and professions. For our staff to provide excellent care to local people, they need to feel well looked after and supported and have access to opportunities to grow their skills and talents.



We are working with local communities to understand what is most important to them

In developing this strategy, we have reflected on insight from our local communities, which partners across the partnership have sought in a number of ways. We considered the below in creating our strategic priorities.

What we did

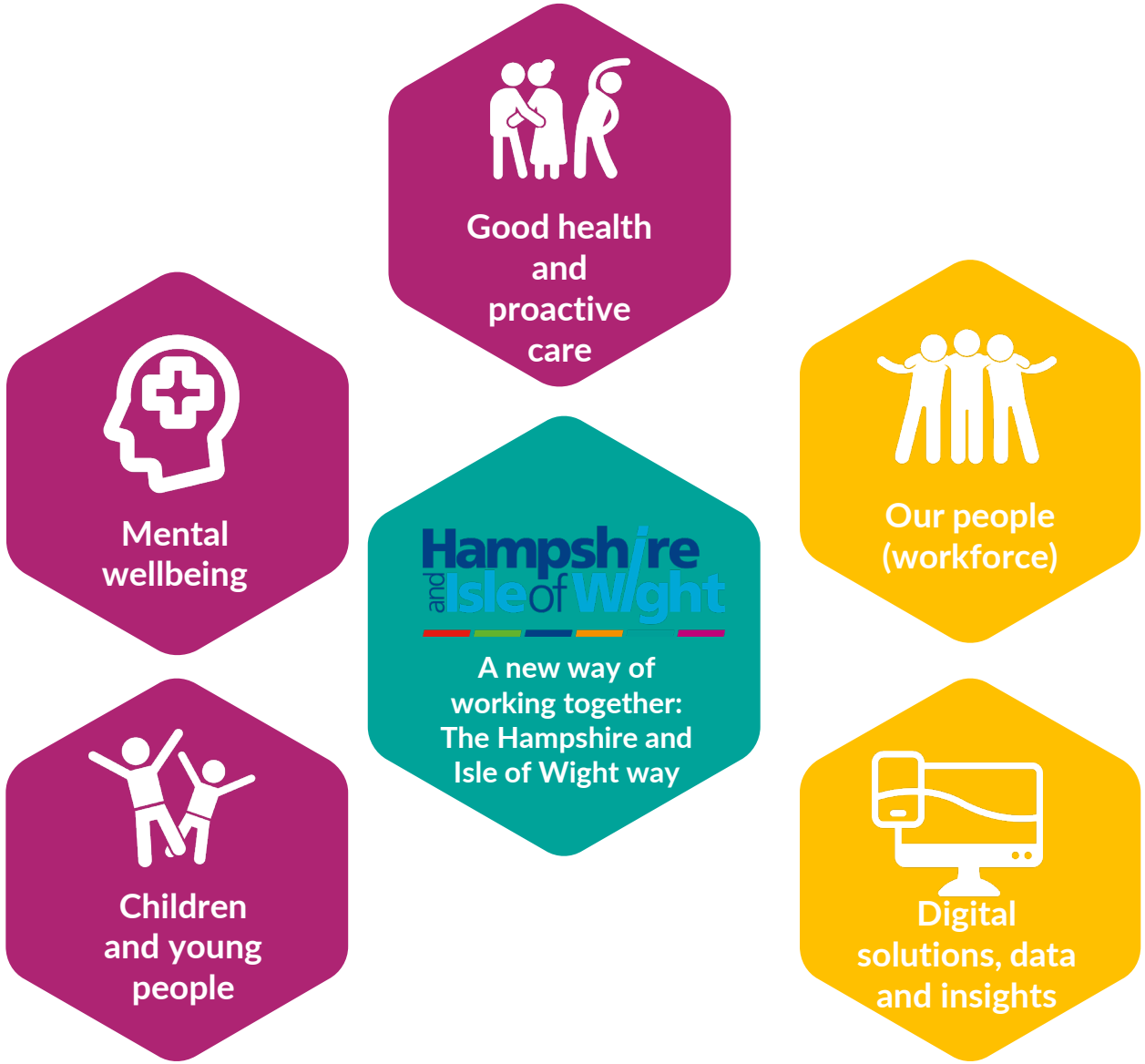
- Surveys on a range of topics, online and face to face, in clinical and community settings, with many directly targeted to different local communities
- Co-design groups, workshops and events on topics such as our community involvement approach, digital transformation and the development of the new integrated care partnership
- Attended local community events, both in person and virtually
- Discussed issues at regular integrated care board and other groups with representatives from across communities
- Focus groups on a range of topics
- Funding partners such as Healthwatch and community groups to undertake targeted research
- Engagement programmes to support procurement and transformation plans

What we heard

- People want more join up between different services, from GPs to hospitals to social care; education and housing too
- People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them
- Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography
- Whilst people say digital technology has its benefits, it is important to ensure that no-one is left behind. Face to face appointments are still highly valued
- Cost of living is a concern across the system. Also people see opportunities to improve and expand the health and care workforce including use of volunteers
- Other issues weigh on people too. For example, in rural areas, equipment and plant theft are big concerns. In urban areas people are concerned with protecting their homes and property
- Carers and young carers support, and greater collaboration with schools, primary care and other health services is vital

Hampshire and Isle of Wight

Our strategic priorities



Core to our strategy: a new way of working together in partnership

We are thinking and acting beyond the core services we deliver (and the way we currently deliver these services) to focus on improving the overall wellbeing of our population. Links between our services and the way people access them, and 'flow' through them –make a big difference to experiences, outcomes and the efficiency of these services.

How will we deliver improved outcomes?

- Through a radically different and more ambitious partnership approach to supporting people to build health, happiness, wealth and wellbeing, recognising the importance of the wider determinants of health and focus on reducing health inequalities.
- Providing high-quality **care and support for our population** built on collaboration between all partners removing any artificial divides and using our collective resources to best affect, making decisions based on data, intelligence and insight
- Promoting greater **community empowerment,** based upon a strengths-based and trauma informed approach which listens to and works alongside communities.

What are we focusing on?

Five priority areas emerged from our initial assessment of data and understanding insights from people, communities and colleagues – see below.

How will we work as a partnership?

On 28th September 2022 we held an event with a wide range of stakeholders, who will be involved in the integrated care partnership moving forward, to shape our priorities. We developed a set of principles for our work as a partnership, set out below.

The integrated care partnership will:

- Use the voice of the public, communities, people that use services, and our staff to shape our work
- Use evidence on which to base our decisions, looking critically at the wider determinants of health inequalities, innovative and evaluative in our approach
- Focus on where we can make improvements and the experience people have of all our services, making changes centred around local people and populations
- Keep engaging and involving people across the system so that:
  - our priorities are co-produced and all partners have an opportunity to shape them;
  - we understand the priorities driving each of our partner organisations;
  - all partners can recognise the importance and relevance of whole system strategic priorities.
- Not seek to detract from organisations' existing strategies or health and wellbeing board plans. Our work should supplement and support existing plans and strategies.
- Use clear language to describe our work.

Children and Young People

What have we heard from our communities and partners?

"Children and young people are our first priority; they are the future of Hampshire and the Isle of Wight"

- "We know if you get it right in the first 1,000 days, then the chances of positive outcomes are massively increased"
- "If a child enters school with a health inequality, this gap is likely to never close"
- "Adverse childhood experiences can lead to trauma, which may increase the risk of cardio-vascular disease, poor mental health, obesity, not educated, repeat victim and perpetrator – if we can work together on it will really benefit us"
- Young carers are cut off and potentially suffering from social isolation

The outcome we want to achieve: We want all children to have the best possible start in life, regardless of where they are born, and have positive physical, emotional and mental wellbeing.

Areas for improvement

- **Best start in life:** Many babies and mothers missed out during the pandemic, which exacerbated health inequalities and led to increasing obesity, mental health issues and missed vaccinations.
- **Obesity**: the England average is 9.9% in reception year - children on the Island and Portsmouth are above this, and Southampton is 9.8%. The British Medical Journal reports hospitalisation, illness and avoidable long term conditions could be reduced by 18% if all children were as healthy as the most socially advantaged.
- **Mental health:** Children whose parents have a mental health disorder, those in a family with unhealthy family functioning, and/or in lower income households are more at risk of developing a mental health disorder. 16,485 children and young people accessed NHS funded mental health services in 2021/22 (37% more children than in 2019/20). When compared to their peers, children under the care of mental health services are almost 20 times more likely to enter the judicial system. We've seen a 295% increase in referrals to children and young people inpatient services since the start of the pandemic (over 50% of this for specialised eating disorder services)
- Increases in **Education Health and Care Plans** for children with Special Educational Needs and Disabilities.
- **Looked-after children and young people** have poorer outcomes including mental and physical health, education and offending rates.

What do we know works?

- If children and families **get the best start during pregnancy and in a child's first 1,000 days** of life, then the likelihood of that child going on to achieve more through education, maximise their potential and lead healthy independent lives increases.
- **Intervening early**, redirecting resources towards prevention and working restoratively with families and individuals supports them to build on their own strengths and resilience to improve their lives. Family hubs provide additional resource in three geographies to extend and deepen family support programmes and support parents early on in their parenting journey
- **Strong integrated pathways of support** eg: there is strong evidence in Portsmouth that children want school based support on healthy lifestyles and mental health support. Early support for child emotional wellbeing including schools based programme - e.g. My Happy Mind.
- **Peer support** groups for pregnant women and their families
- Focused, family-based multi-professional support for **children with neurodivergence**.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Focusing on the **"best start in life"** by ensuring families receive good care and support (including for their mental wellbeing) during pregnancy and in the first 1,000 days of a child's life
- **Improving access and mental health outcomes** for children and adolescent mental health services
- **Working with schools and other key partners on prevention and early intervention** to reduce the risk and increase protective buffers at an individual, relationship, community and societal level, e.g.: encouraging physical activity to support mental and physical health. Focus on direct causes of ill health and wider determinants of health and wellbeing. Meeting the health needs of vulnerable groups including 'looked after children', care experienced young people and reducing violence against women and girls.
- Continuing our **trauma-informed approach** led by Public Health, Police and Crime Commissioner and Hampshire and Isle of Wight Constabulary
- **Redesigning and co-locating services** to enable a family-based approach to accessing services, co-designed with parents and carers to ensure a 'whole family approach'
- Further developing a **joint children's digital strategy**

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, improved educational attainment, better inclusion and engagement in schools, societal benefits e.g. reduction in crime
Our staff: reduced pressure and increased satisfaction at work
Partners: positive impact on society and the economy, reduced demand for services in the future.

Mental wellbeing

What have we heard from our communities and partners?

"The non-clinical route into mental health and wellbeing support is just as important as the clinical route"

- Prioritising and promoting mental health and wellbeing is a priority across all partners, for all population age groups
- "Focus on illness is too strong and should be more of a focus on wellness"
- "Secondary care in mental health is just the tip of the iceberg - there needs to be many rafts of supporting scaffolds in place"
- "We need to challenge ourselves that access is the same and equitable", and continue to improve parity of physical and mental health
- We need to state tangible solutions with ambitious targets and do a few things well

The outcome we want to achieve: improve the population's mental health, emotional wellbeing and physical health, by focussing on prevention and working more closely with communities in the provision of excellent, equitable, joined-up services, care and support.

Areas for improvement

- **Prevalence of mental health conditions varies across our geography**, e.g. the Island has the highest prevalence of severe mental illness, followed by Southampton and Portsmouth
- **Mental health problems have greater and wider impact in some groups than others**, e.g. the largest proportion of the population claiming Employment Support Allowance due to mental health problems is those aged 18-24yrs; impacts are inequitable in deprived and ethnic minority communities
- **We are below the national average and peer top quartile for some services**, e.g waiting times for children and young people, people living with a serious mental illness who have not had their regular 'physical health check' in primary care, and below national targets for improving access to psychological therapies and dementia diagnosis
- **There is a mismatch between the needs of population and the capacity of services**, and this varies across our system, so some people more impacted than others
- **Far reaching mental health impact of Covid19 still to be fully realised**; but has exacerbated inequalities for marginalised people/groups, especially those struggling with their mental health and wellbeing before the pandemic.

What do we know works?

- **Collaboration and determined focus on prevention and early intervention** e.g. Isle of Wight's Mental Health Alliance, partnering between Shout mental health text service & 111 Mental Health Triage Team, social prescribing.
- **Single points of access and 'no wrong door' approaches** - through join up between local authorities, primary care and voluntary care / social enterprises, improve the quality and availability of urgent care
- **Lessening the stigma around mental health and wellbeing** – coordinated communication campaigns between services / organisations e.g. 'Its OK not to be OK'
- **Digitally enabled support and care**, e.g.: psychological therapies and advice and information
- **Adopting 'outreach' approaches** through other healthcare interactions e.g. dentists, opticians to identify individuals who may be at risk
- **Expanding access to support in local communities** via innovation between partners e.g. co-location of services, mobile/pop up support in 'trusted' places where people live or gather e.g. Hampshire Homeless Health Teams, Joint work with Faith Leaders (Covid 19 Vaccination)

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Emotional wellbeing** and prevention of psychological harm - including excess morbidity and excess mortality associated with severe mental illness and promoting attachment in early years.
- **Improving mental health and emotional resilience** for children and young people, especially as they move into adulthood, and for families, parents and carers of children
- **Better connecting people** to reduce loneliness/isolation
- Focused work to **prevent suicide**
- **Improving access to bereavement support** and services
- **Addressing inequalities in access and outcomes and enabling people to navigate through services**
- Ensure people with **serious mental illness** can access the right help and support when needed
- **Provide a greater focus on support with addiction** including drugs, alcohol and gambling

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, greater independence, and for children and young people - improved educational attainment
Our staff: reduced pressure and increased satisfaction at work
Partners: increased effectiveness, improved productivity and workforce supply (resulting from improved mental health and physical health and/or reduced caring responsibilities for others with mental health support needs), positive impact on the economy, unmet need recognised and addressed.

Good health and proactive care

What have we heard from our communities and partners?

"We need to be tackling the 'causes of the causes' of people's ill health"

- If trends continue, preventable ill-health and deaths will grow, as will health inequalities and our services will become increasingly unsustainable. There is a great deal we can and are doing, but there is more we could do together
- Deprivation is often hidden in rural communities – we need to prioritise areas of greatest need/ inequality – recognising we can't do all of this at once
- There is a role for all partners in improving health of our population, not just in terms of managing the conditions that people have already been diagnosed with, but addressing some of the wider determinants of health, so that people can live more years in better health.

The outcome we want to achieve: We want to narrow the health gaps between the richest and poorest, enable every individual to live more of their life in a state of good health, and make sure people can access resources and services in their communities to manage their own health and wellbeing.

Areas for improvement

- **Outcomes vary widely**, eg: some of the lowest avoidable and preventable mortality rates in some areas, other areas significantly above national median
- **Some people suffer poorer health and die younger**, eg: people with learning disabilities (life expectancy 14 years less for males, 18 years less for females), people who are homeless, gamblers, refugees, carers, people with mental health needs (eg: a person with schizophrenia dies up to 20 years earlier, the last 7 years in poor health)
- **The greatest contribution to life expectancy gap** between the most and least deprived is linked to circulatory diseases, cancer and respiratory diseases
- **Stagnating life expectancy improvements** particularly in the more deprived areas, (especially females). Time spent in good health has decreased
- **Impacts wider then health**, eg alcohol and drug misues lead to higher propensity to be a victim or perpetrator of violence
- **These outcomes can be changed,** eg: smoking remains the biggest preventable killer and major contributor to health inequalities; alcohol admissions are increasing, particularly in Southampton and west Hampshire; top issues noted in patient records: 1. hypertension, 2. depression, 3. obesity
- **Feeling isolated** is linked to early death, poor health and wellbeing - social isolation is associated with a greater risk of inactivity, smoking, risk-taking behaviour, coronary heart disease, stroke, depression and low self-esteem.

What do we know works?

- **Taking a life course approach** recognising there are a wide range of protective and risk factors that influence health and wellbeing over the life span and that people's outcomes can be improved throughout life
- **Reducing health inequalities** through the life course requires a whole-of-society approach dealing comprehensively with all health determinants. We know that clinical care only contributes to 20% of an individual's health outcomes and therefore to improve our population health and wellbeing we need to focus on the other contributing factors, eg: health behaviours (smoking, diet, alcohol), socioeconomic factors (family/social support), the environment people live in (housing)
- **Promoting healthy behaviours** eg: healthy diet, healthy weight, physical activity, smoking cessation - helps with major conditions i.e. cancer, depression, dementia, diabetes and cardiovascular disease.
- **Better connecting people** (tackling social isolation) improves health outcomes and reduces the need for health services and residential care, supports employment and increases workplace productivity. Services which build on the community model of empowerment, like social prescribing, voluntary and community befriender services and local government community connector services all have positive impacts. These services can deliver up to a 68% reduction in using services; up to 88% of people who access these services have a better understanding of their community support and a 10% increase in wellbeing measures eg: connectedness to others.
- **Providing proactive, integrated care for people**, especially those with complex needs, providing care closer to home, shifting focus to prevention, and reducing reliance on support services including urgent or emergency care.
- **Core 20+5 approach** to health inequalities: focusing on the most deprived 20% of the population plus other local population groups experiencing inequalities in five clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Improving social connectedness and support in communities –** leveraging existing community assets and empowering citizens across all stages of life, building overall community wealth
- **Providing support for healthy behaviours and mental wellbeing in community settings;** targeted approaches on evidence-based issues eg: lung health checks, vaping prevention in children, visual impairment for those with learning disabilities, reducing the direct health harm and broader population impact of unhealthy relationships with drugs and alcohol, increased physical activity
- **Ensuring equal importance is given to mental wellbeing and physical health** and tackling the stigma of mental health
- Supporting people to minimise the potential health and wellbeing impacts of **cost of living pressures**
- **Providing proactive, integrated care** for people with complex needs, including frailty
- **Supporting healthy ageing and people living with the impact of ageing**, providing bespoke support to people that may be at greater risk of poor outcomes due to old age, building prevention into pathways, eg: smoking, obesity, 5-a day, physical activity, alcohol, drugs
- **Combining resources** on housing, mental health, refugees, homeless, rough sleepers and 'Core20+5'

What are the benefits for:

local people: no matter what a person's circumstances are, they can be assured of dignity and security as they age; improved health, happiness, wealth and wellbeing; longer lives and increased overall years of good health
our staff: reduced pressure and increased satisfaction at work, with a focus on prevention and early intervention
partners: people living longer, healthier, happier, wealthier lives which reduces demand and unmet need, delivers efficiencies, improved effectiveness

Our people, digital technology and data are key to enabling us to deliver our priorities

Our people: the people that work across all our services are vital to the delivery of this strategy. We have a highly skilled, dedicated and committed workforce across Hampshire and Isle of Wight, including a huge contribution from volunteers and informal carers.

External factors lead to increased demands on services and the people that deliver them. People are living and working longer, necessitating radical changes in how we structure work, e.g.: flexibility, mid-career shifts, re-skilling, and delayed retirement. The health and wealth of the workforce affects the health and wealth of local people. In the NHS, 1 in 4 staff members are 'lower paid' (defined as earning up to £12.73 per hour in 2021/22, just below average UK hourly earnings). By comparison, around 4 in 5 social care employees are 'lower paid' by the same measure. Our workforce has faced unprecedented challenges over the Covid-19 pandemic and demonstrated exceptional resilience, including adopting new practices to sustain services for the benefit of local people.

Our workforce is stretched, both in Hampshire and Isle of Wight and across the country. Workforce wellbeing remains a key priority across all sectors. In June 2022 alone the NHS lost 476,900 days (nationally) to sickness and absence due to anxiety, stress and depression. As of September 2021, nearly 100,000 NHS vacant posts, and 105,000 in social care were being advertised nationally. An estimated extra 475,000 jobs are needed in health and 490,000 in social care across the country by the next decade. We recognise the imperative to re-examine the way we work and innovative delivery pathways supported by digital technology.

Workforce challenges in Hampshire and Isle of Wight

- Domiciliary care workforce shortages, particularly in Isle of Wight, south-west and south-east Hampshire
- NHS workforce supply pipelines unable to keep pace with current demand, particularly for nursing, midwifery, medical and allied health roles
- Our workforce is not representative of the communities we serve, which might then impact on the inclusivity of services we provide
- Staff morale and engagement scores are generally declining across the NHS.

Digital solutions, data and insights: harnessing the power and innovation of technology and information technology will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles. Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient. It is vital that we are able to share data across our partnership that enables us to develop a shared picture of where there is greatest need and inequality. This will support new, trusting, more informed ways of working across organisations Data held by the NHS, and generated by smart devices worn by individuals, presents opportunities to support everyone with access to their health information and personalise many more health and support interventions.

However, the complexity, cost and time it takes to introduce some new digital solutions, join up data and create insight we can act on continues to present a challenge. Additionally, most local people understand the benefit of digital solutions and shared data, but we must continue to be respectful of the views and preferences of those who still have reservations or are unclear.
For example:

Sharing patient information

A Wessex Care Records survey highlighted:

- 86% of respondents understood their information was shared for their care and treatment, but less were aware it was shared for planning services (46%)
- Respondents were positive about potential future uses such as sharing for planning and improving services (77%)
- There was less support for sharing with other organisations, i.e.: the charities/universities carrying out research (58%), other organisations, such as councils, providing care and support (53%) and companies developing new treatments (38%)

Face-to-face still highly valued

Hampshire Fire Service asked what people thought the challenges were to accessing services. Respondents said access to technology was the main barrier (46% said face to face communication was best)

Remote monitoring needs to be effective

Healthwatch England asked people about their experience of remote monitoring. People said there are many benefits to blood pressure monitoring at home, including peace of mind, feeling in control and convenience, but there are serious questions about whether the benefits of better health are being realised and gaps in GP processes need to be addressed to avoid demotivating people and missing opportunities to address blood pressure problems.

Our people (workforce)

What have we heard from our communities and partners?

"Without the workforce, none of our ambitions will be achieved"

- "We can't do anything without our people. They need to be supported, inspired and have good access to continuous development.
- "[We need] a workforce that is engaged, empowered and always learning and striving to improve."
- "There is the opportunity join up our training and retention offer, including creating employment opportunities for our local population to improve their health outcomes"
- Reductions in workforce puts pressure on loyal staff and shortages are getting worse across all roles
- The rising cost of living is creating downward pressure on the real wages of our workforce and making it even harder to recruit
- Our workforce doesn't match need with some areas very well served and others (often more deprived) areas underserved
- There is some duplication in roles, especially between "first contact" staff

The outcome we want to achieve: We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight.

Areas for improvement

- Untapped resources in voluntary and community sector
- Increasing sickness absence rates, eg: NHS increased to 5.2% in June 2022; 23.2% of sickness due to anxiety, stress, depression and other mental health
- Annualised growth for the health workforce is 4% per year over the past five years, but there is still shortfall, NHS vacancies at 10% in south east region April –June 2022. 2021/22 NHS staff retention rate at 14%
- At the time of the 2011 census, there were 39,437 unpaid carers across our system providing for family members or friends. The total number is now likely to be much higher. However, during Covid-19, we have seen a breakdown in unpaid carer arrangements and voluntary and community sector care support is also compromised. Many of the people being supported in this way are living with long term, often life long, care and support needs. Without the amazing commitment and dedication of unpaid carers the health and care system would quickly come to a standstill.
- Shortages in one workforce group results in additional pressures on other agencies, eg a shortage of specialist mental health staff has an impact on police, who are not the most appropriate to deal with those in crises.

What do we know works?

- Concerted focus to improve diversity, inclusivity and belonging and the development of a universal workforce
- Collaboration in recruitment and retention, including international recruitment
- Making every contact count
- Health and wellbeing at work, including support for menopause and staff fast track referrals into support services
- Joining up pathways into education around healthy lifestyles into care, health and voluntary sector roles
- Levelling up through employment - securing good work is a key indicator to improve individual, and collective, health and economic wellbeing outcomes
- Organisational development networks across partner organisations to work together on development and share best practice
- 'Education to employment' projects working with schools and colleges
- Joint leadership and transformation programmes eg: Hampshire 2020 programme

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Evolving our workforce models and building capacity to meet demand: Grow the workforce for the future by extending recruitment and working closely with education providers, building our ability to share system resources and move between organisations, harness the untapped support of volunteers and implement effective, collaborative workforce planning which accounts for labour market flows across health and care sectors and their interaction with the wider economy, designing innovative new workforce models and roles with career pathways
- Ensuring the availability of the right skills and capabilities to deliver, safe high-quality care.
- Ensuring people who provide services are well supported and feel valued, taking a system-wide approach to organisational development and support offers for our staff, including access to mental health first aid support and trauma counselling, and supporting people with unpaid caring roles, as well as improving diversity and inclusivity.

These initial actions focus on the critical issues in health and care workforce; however, the partnership is committed to workforce solutions that benefit all partners.

What are the benefits for:

Local people: better availability of staff with the right capabilities means better access to high quality services. There is a direct link between staff feeling supported and valued and being able to deliver high quality, compassionate care.

Our staff: increased fulfilment, increased job and career satisfaction, lower levels of stress, avoid duplication of recruitment and training requirements, feel able to deliver care of the quality to which they aspire, improved personal health and wellbeing.

Partners: improved workforce supply and pipeline; creation of new roles to support delivery of key priorities at place (e.g. case management). If staff shortages in one part of the system are addressed, this has a positive impact on workforce capacity across all sectors. Positive impact on the economy and wider determinants of health for local people employed locally.

Digital solutions, data and insights

What have we heard from our communities and partners?

"There is a known need for digital systems to be integrated and compatible: without this there is a decline in efficiency and collaboration"

- "A shared single picture of vulnerability is essential so that we can target activity to the sections of the population that need it most"
- "It's about the enablers. That's where we can get traction as a system"
- Systems are not connecting with each other: too many systems creates duplication. We are wasting time by not have the right access to the right equipment or networks to do work in real time.
- Increased awareness and concern about digital exclusion. This is not just about access to computers and the internet, but includes issues such as privacy, disability and access for carers.

The outcomes we want to achieve: 1. We want to harness the benefits that digital solutions can offer to our local people, carers and staff, ensuring they are available to everybody, regardless of age, disability or household income. 2. We want to develop our shared picture of which population groups have the greatest need – we will do this through building a rich, joint partnership data picture, and use this to develop the best services and support for the people of Hampshire and Isle of Wight.

Areas for improvement

- People are now using **digital tools for online consultations**, accessing their GP record, and to seek advice and guidance.
- **Digital exclusion** is having an increasing impact on the most vulnerable in our society. People that are digitally excluded often pay more for household bills, earn less, have lower levels of educational attainment and can suffer more from social isolation, which impacts on both mental and physical health.
- We have a **range of different IT systems** that do not all "talk" to each other.
- Our **data sets** are not yet as sophisticated or joined up as they need to be. Consequently, our activities as a partnership lack the evidence base that could be available to enable excellent decision making including individual care and service planning.
- Health and care can be **slower to adopt** digital innovation.

What do we know works?

- **Giving local people more control of their care** for example by sharing your Covid-19 status or ordering repeat prescriptions through the NHS App or viewing your latest test results and communicating with your healthcare professional via 'patient portals'.
- **Providing users with simple secure access to the information they need**, for example by providing care homes with access to the system-wide shared care record to see any new patients history such as medications and allergies.
- **Bringing information from multiple sources together in one place** and reducing the number clicks and logins, for example with single sign on to the shared care record or through electronic patient record portals.
- **Reducing unnecessary travel time** for staff and people using services by providing secure mobile access to systems and giving people the choice of virtual consultations.

Our areas of focus as a new integrated care partnership:

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in the following areas:

- We will **empower local people** to use digital solutions through promoting and engagement in digital services. We will provide resources and support for local people to engage in digital to ensure equity of access to all health and care services
- We will **support our workforce** to be confident and competent in using digital solutions to provide high quality care
- We will **improve how we share information** between organisations and remove the organisational, digital, data and technology boundaries created by legacy systems to better support care provision and the creation of integrated datasets to support planning.
- We will **continue to improve our digital solutions**, focusing initially on investment in shared electronic health and care records. We will explore digital innovations in improving health and modernising care and experience, including the use of apps and wearable devices

What are the benefits for:

Local people: can receive care at home, where appropriate and only need to say things once. People feel they are always involved and have control of their own care, can access care and information in a way that meets their individual needs and helps them to make choices about their own health and wellbeing. Our local people do not feel digitally excluded and can access to a range of services.

Our staff: can access equipment that is modern, reliable and fast, and helps productivity, releasing more time for providing care. Staff can review and update patient records when and where they need to, using joined up systems that talk to each other. Staff can easily communicate with colleagues across different organisations involved in the care of local people.

Partners: Reduced efficiencies by saving staff time and avoiding duplication; facilitates joined up care and services; enables real-time, consistent capturing of information which improves our understanding of people's needs and helps decision making; enables joined up data sets to support better planning, including our population health approach.

How we will deliver our partnership strategy

Our response to the needs of our population is primarily through our work in local places

This strategy draws upon the work of our four health and wellbeing boards and their strategies and plans in our four local places - Hampshire Southampton, Portsmouth and the Isle of Wight.

Our strategy identifies a small number of priority areas where there is an opportunity to add value across our four places, recognising that most of the work undertaken to tackle health inequalities, improve health outcomes and service delivery, and contribute to social and economic development is delivered in local places.

These are the themes that are common to all four local health and wellbeing strategies:

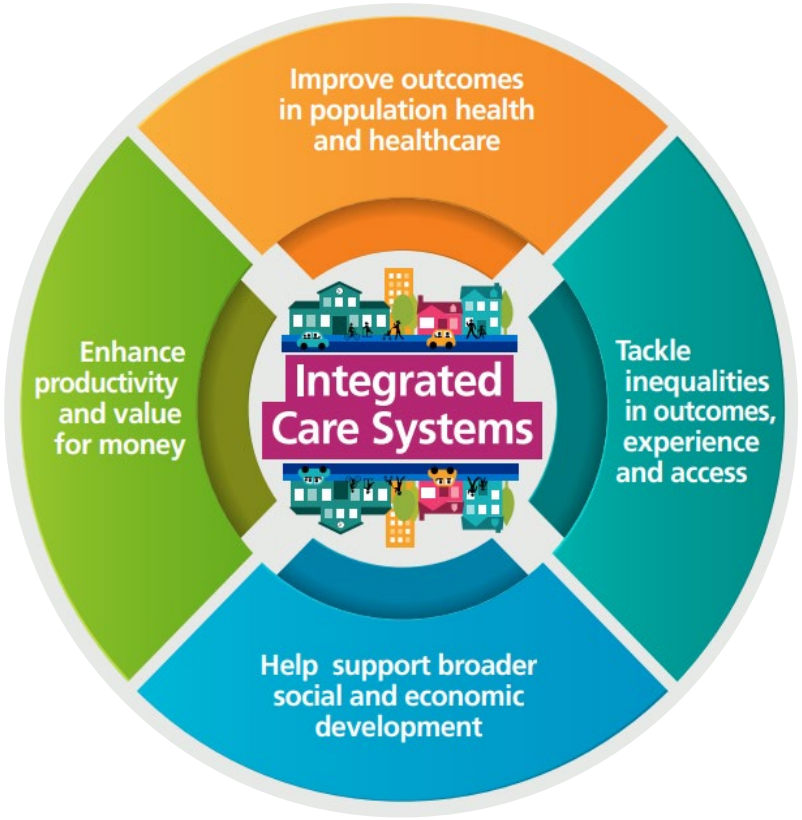
Children and Young people	Reduce Inequalities Work with parents, families, schools and early years settings Improve physical wellbeing and improve lifestyles Improve emotional wellbeing and mental health
Living Well and Improving Lifestyles	Encourage healthier lifestyle choices and healthy approaches in schools and organisations Promote mental wellbeing and reduce mental ill health Promote active travel, create a greener, cleaner environment
Connected Communities	Joined up approaches across providers Building community networks Building on social capital
Housing	Ensure residents are able to live in healthy and safe homes Ensure home environments enable people to stay well Recognise and ensure that communities and families are not adversely impacted through poverty

Hampshire	Enable planning for older age living Ensure Palliative Care Collaboration is in place Support those at end of life to be in preferred setting Encourage improvement in skills and capacity to have early conversations on end of life Improve bereavement support and service locally
Isle of Wight	Invest in prevention and early intervention to help health and wellbeing Improve housing standards and reduce fuel poverty, social isolation and loneliness Include health inequalities in policy development and commissioning Reduce health inequalities
Portsmouth	Provide immediate support to people in financial hardship Helping people access the right support at the right time Repair relationships to support our most vulnerable Develop stronger models of support for landlords and tenants for longer, successful tenancies Develop models of housing that suit individual needs Implement Homelessness and Rough Sleeping Strategy to provide support for the most vulnerable
Southampton	Support people to live active, safe and independent lives and management their own wellbeing Reduce inequalities in health outcomes, make Southampton a healthy place to live and work with strong and active communities Ensure people in Southampton have improved health experiences as a result of high-quality integrated service

The work we do together as a whole integrated care system complements and supports the work that we do together in our four places

What is an integrated care system?
NHS England defines an integrated care system as “partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.” (NHS England » What are integrated care systems?)

The purpose of integrated care systems is to bring partner organisations together to:



Every part of our integrated care system has a role to play in delivering the priorities set out in this strategy.

Our **four local places** analyse the health and care needs of their residents and set local strategies for meeting these needs in their area. Their work feeds into and informs this partnership interim strategy document. The four places take local action to deliver for the needs of their local communities alongside the priorities agreed in this document.

The integrated care partnership develops the strategy to address root causes of health and wellness, tackle health inequalities and bring partners together to work together in new ways. The integrated care partnership sets strategic priorities based on sound evidence and that are within our gift to tackle as a partnership.

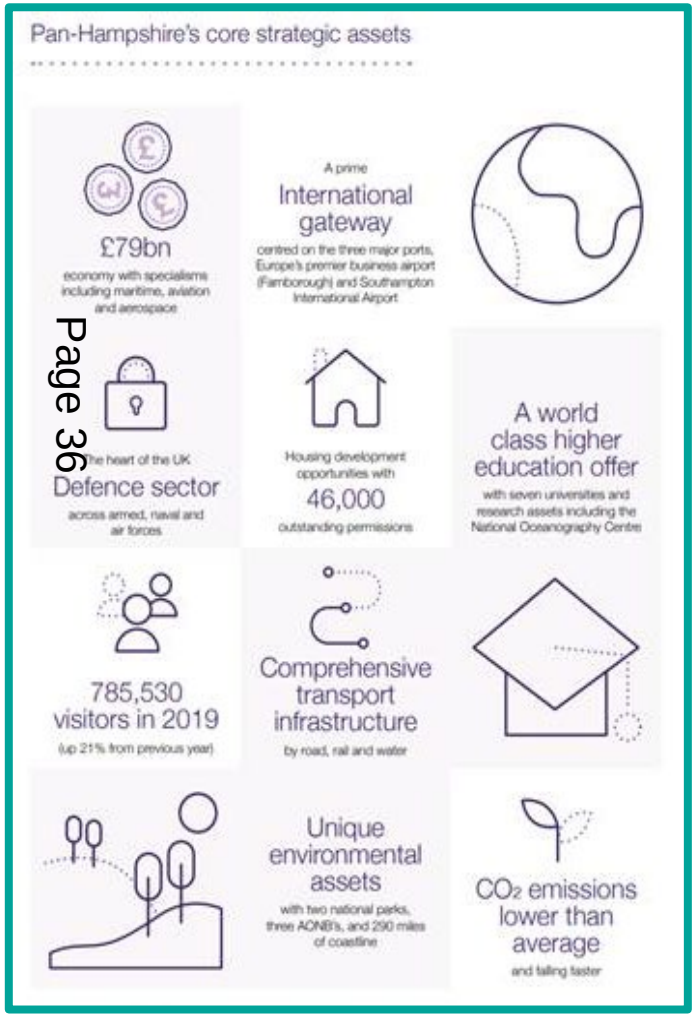
Our **Integrated Care Board** is responsible for planning NHS services across Hampshire and Isle of Wight and allocating resources across all health services. The integrated care board will ensure that the planning, quality monitoring, improvement and transformation of health services aligns and contributes to the priorities described in this partnership strategy.

Organisations come together in **collaboratives and networks** to address particular strategic themes.

Each organisation in our integrated care system sets strategies that address the challenges and opportunities facing their specific organisation. As partners that have worked together to agree partnership strategic priorities, these organisations will ensure that their organisational strategies contribute to the delivery of the priorities set out in this document.

Using our collective strengths and assets

Our strategy focuses on a small number of initial priority areas to make the best use of our combined resources, including the strengths of our local communities and our ***strategic assets*** across Hampshire and the Isle of Wight. As we work together to deliver our priorities, we will also develop the way that we work together as a partnership, continuing to learn together and draw on our collective insights and talented people. Our approach focuses on the strengths of individuals, community networks and other assets – and not their deficits – led by a focus on outcomes rather than a focus on services.



The strength of our communities

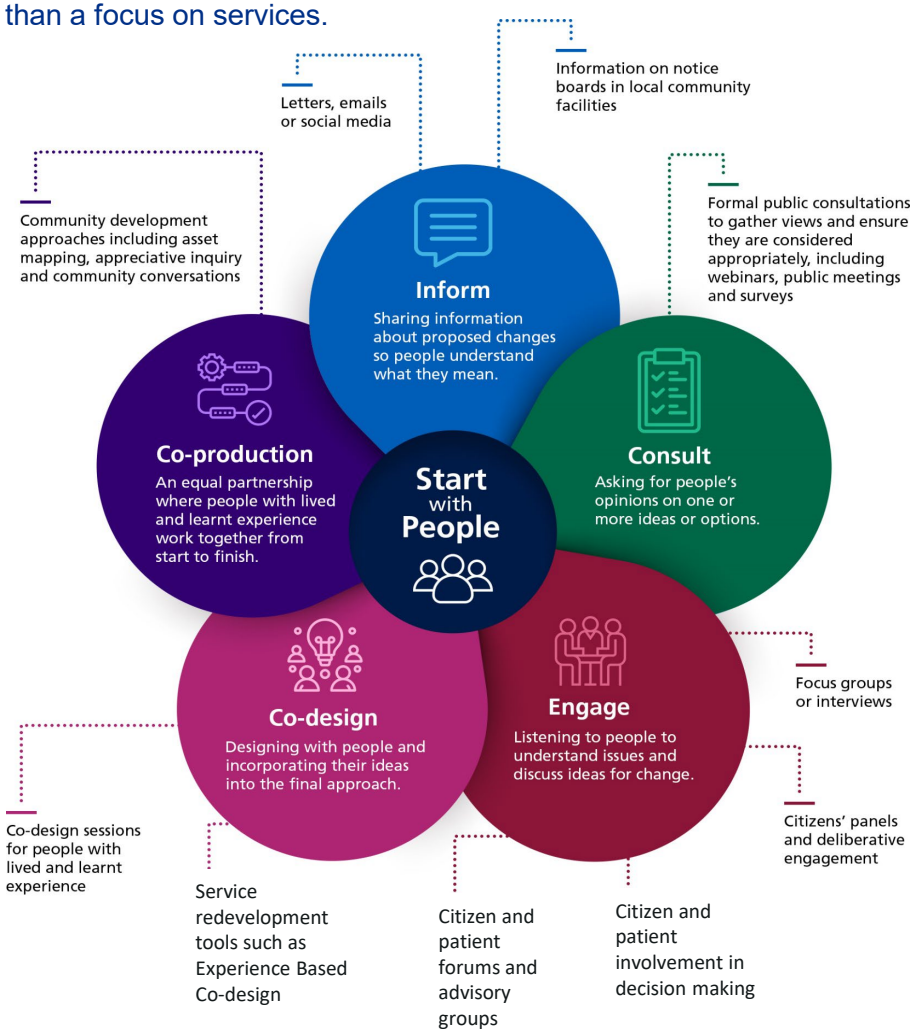
Our ambition is it to harness the resources, skills, knowledge and experience of the communities we serve. We have strong communities, within which many people give their time and skills as volunteers, and thousands of people providing unpaid care to their loved ones. Our voluntary, community and social enterprise sector is a significant asset and makes a huge contribution to our communities.

Thousands of students attend higher education here and we are home to outstanding centres of research and innovation in our local universities industry and academic health science network. We have a thriving cultural scene and industries providing employment and infrastructure.

Using these assets we will address health inequalities, improve and innovate the way we deliver services, support economic growth and support local people to improve their health, happiness, wealth and wellbeing.

As described earlier, we have drawn upon insights from local people to inform this interim strategy. Our community involvement approach, incorporates many ways of working with local people (see right), and builds on existing best practice here and in other places, strengthening the valuable relationships we have, and meeting the needs of our diverse communities.

As part of this, we are launching a project aimed at supporting under-served communities to participate in research to improve access, resources and support. The project brings together voluntary; community; social enterprise; local government; health and adult social care partners, the University of Winchester and people with lived experiences. This will be instrumental in the delivery of this strategy and our ongoing work as a partnership with our local communities.



Developing our learning system

Together we will design a learning and improvement system, building on excellent practice across Hampshire and Isle of Wight, and drawing on evidence and best practice from the highest performing health and care systems nationally and internationally. We will develop a unified approach to change and transformation, and how we will deliver the best outcomes for local people, making the best use of our resources. This will have implications for how we plan, design, deliver and sustain change and improvement. Key to this are our collective insight and innovation capabilities.

Our population health approach: building capability across the "four Is"

Building these capabilities will enable us to deliver a population health management approach to support us in delivering our strategic priorities. Through good population health management we can target groups of people with greatest need with the best type of evidence-based support.

Infrastructure

Organisational and human factors such as dedicated systems leadership and decision making on population health and PHM

Digitised health & care providers and **common integrated health and care record**

Linked health and care data architecture and a single version of the truth

Information Governance – whole system data sharing and processing arrangements that ensure data is shared safely securely and legally

Intelligence

Advanced analytical tools and software and system wide multi-disciplinary analytical teams, supplemented by specialist skills

Analyses and actionable insight – to understand health and wellbeing needs of the population, opportunities to improve care, manage risks and reduce inequalities

Alignment of multi-disciplinary analytical and improvement teams to work with and advise providers and clinical teams

Development of a cross system ICS intelligence function providing support to all levels of system

Interventions

Care model design and delivery through' proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities

Community well-being – asset based approach, social prescribing and social value projects

Citizen co-production in designing and implementing new proactive integrated care models

Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle

Incentives

Incentives alignment – value and population health based contracting and blended payment models

Workforce development and modelling – upskilling teams, realigning and creating new roles

Enabling governance to empower more agile decision making within integrated teams

Research and innovation

There are vast opportunities for research and innovation to help address challenges around:

- workforce (including health impacts on employment and improving workforce efficiency)
- mental health and wellbeing, particularly for children and young people
- new approaches to care for people living with long term conditions and for older people
- making the best use of digital solutions
- accessing routine care following the Covid-19 pandemic.

Some of these innovations help us to better deliver the right things at the right times in the right place, making the most efficient use of workforce and empowering people in their own lives. Other innovations drive technical efficiencies in established pathways of care. As in other global health systems, the adoption of innovations in health and care is patchy, driven by the way innovation is prioritised and funded. In the United Kingdom, we invest heavily in invention, but our ability to make use of inventions does not always keep pace.

Working as an integrated care partnership allows us to better align all the organisations in our system to make better use of innovations. Other factors that support this include the merging and therefore better alignment of central bodies, and our collective experiences of working through the Covid-19 pandemic, which changed our understanding of what is possible and how to enable rapid invention, adaptation and use of innovations. In Hampshire and Isle of Wight we will seek out research and innovation that directly supports our five strategic priorities, work out how these can be adopted across our partners and services, and develop our capacity and capability to sustain and spread innovations as part of our learning system approach. In doing so we will make best use of:

- Relationships with academic networks and institutions
- Commercial support and relationships with industry
- Design support and implementation science
- Real world evidence about what works well
- National networking, sharing, learning and supporting.

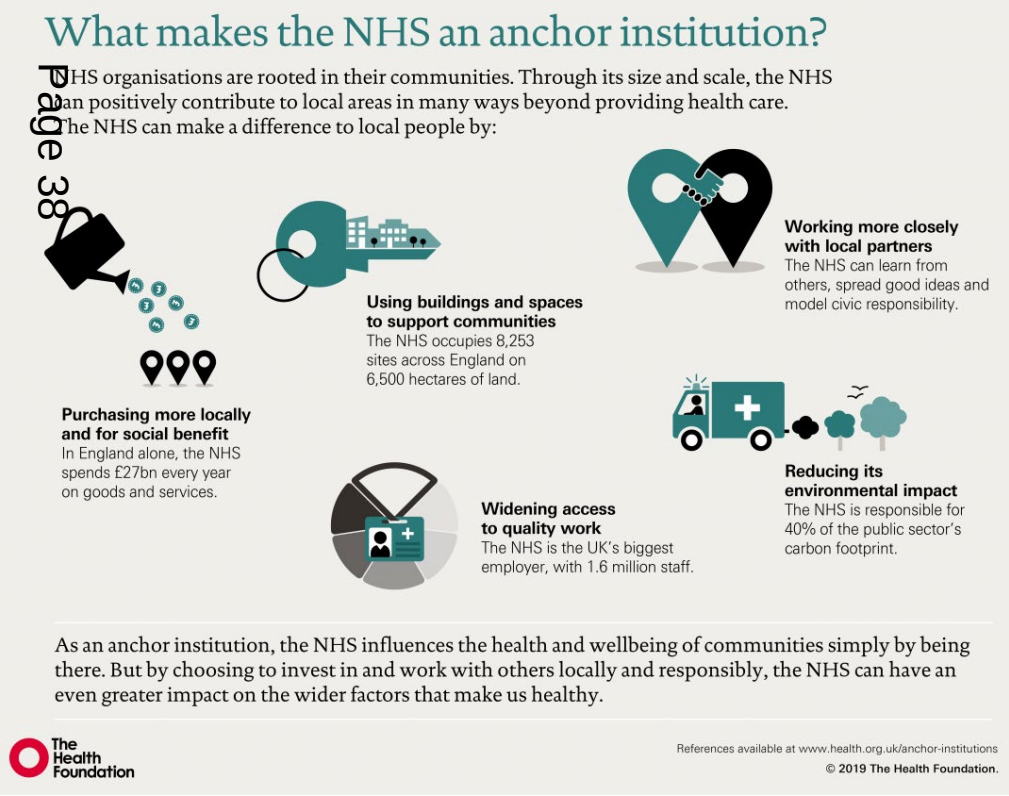
Ensuring our organisations benefit broader society and support environmental sustainability

Our organisations as "anchor institutions"

Large businesses, local authorities, NHS and other public sector organisations, are rooted in their local communities and can make a big contribution to local areas in many ways, far beyond our core purpose as organisations. The term ***anchor institutions*** refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on local health and wellbeing.

The Health Foundation developed the graphic (bottom left) to show how NHS organisations act as anchor institutions in their local communities. Although the graphic refers to the NHS, the same principles apply to partners, including local authorities, universities and large employers; local authorities already do much on their work as anchor institutions.

We are increasingly conscious of our potential to make an even greater contribution to broader society including supporting economic growth and the environment, and are working to better understand and realise this potential. In our workforce priority, we describe our ambition to work together to improve the health, happiness, wealth and wellbeing of local people working in our organisations, and our future workforce, and drawing more local people into employment and volunteering.



Opportunities to work together for a cleaner, greener environment for us all

Another area of focus for us as anchor institutions, is our work to address the climate crisis, as described below.

- **Reducing carbon emissions** through energy and water efficiencies and clean technology installations will contribute to cleaner air across Hampshire and Isle of Wight, and offer the potential to reduce the pressure on our system by lowering rates of chronic disease such as cardiovascular disease in our local population
- **Supporting local biodiversity** through creating or enhancing green spaces on our estate (land) to promote residents, staff and wider community health and wellbeing now and in the future
- **Empowering and supporting our workforce** to make greener decisions through creating an innovative environment, where our people feel able to embrace sustainability practices in their day-today actions and has a positive effect on their wellbeing at work
- **Reducing indirect environmental impacts** and maximising social value by choosing local and conscientious suppliers where possible e.g. maximising efficiencies in transporting of goods
- **Reducing operational waste** including choosing low carbon alternatives such as reusable equipment and reutilising where possible

Our partnership is committed to maximising our positive contribution to our local area wherever possible.

Funding and finance

All system partners are operating within an increasingly difficult national economic environment. Local authorities continue to work creatively with partners and populations to deliver statutory services within revenue and capital resources. At the time of writing, the impact of the recent 2022 Autumn Statement is still being worked through by councils. However, it is assumed that the overarching position remains relatively unchanged. Challenges coping within normal inflationary pressures, over a decade of reductions in core budgets, in addition to the significant unfunded growth in demand and costs, particularly in adults' and children's social care, and the crisis in special education needs, means that some local authorities are now pressing for fundamental change either in the way these services are funded, or in our statutory obligations.

The NHS in Hampshire and Isle of Wight receives £3.6bn for the health and care of its population, equating to approximately £1,895 per head of population. This is a relatively high level of funding per head of population compared to the rest of the country; however, in the context of increasing demand for services and rising costs, we will continue to see a challenged financial environment.

This further demonstrates the need to focus on the priority areas set out in this interim strategy to improve the health and wellbeing of local people. Partners are keen to better understand the totality of our funding envelope and explore opportunities to work together to make best use of the collective funding and resources available.

Nationally and in our system, local authorities are facing financial pressures in adult and children's social care, public health and the broader services that impact health and wellbeing outcomes. At the same time the health and care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector.

Making best use of our resources

As a partnership, we are exploring what we can do to make better use of our resources, including:

- How to deliver efficiencies so that more funding can be made available to deliver our five strategic priorities
- Developing an equity model to ensure investment decisions are driven by population need and support reductions in the health inequalities described in this interim strategy
- All partners collectively providing and driving funding to the right places to ensure best value, care and support for local people
- Making more use of pooled funds through the use of Section 75 agreements between local authority and NHS partners, and similar, where appropriate
- How to operate an 'open book' financial culture
- Developing our shared approach across all partners to taking difficult financial decisions
- Increased contributions to local economic growth.

Section 75 agreements

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

Established section 75 arrangements are already in place between our integrated care board and our four upper tier local authority areas. This mechanism has resulted in a major increase in pooled budgets over the years in some parts of our system, where partners have agreed to share risks and rewards and accountability for outcomes.

Further integration of health and social care, while complex to deliver, is recognised as a much needed response to the challenges of rising demand and budgetary constraints. Our ambition is to utilise the section 75 agreements as the vehicle to further drive integration of services at a local level and also deliver on the strategic objectives of this strategy. We will continue to review the opportunities to use section 75 arrangements to further integrate services as the strategy develops and our place-based partnerships grow.

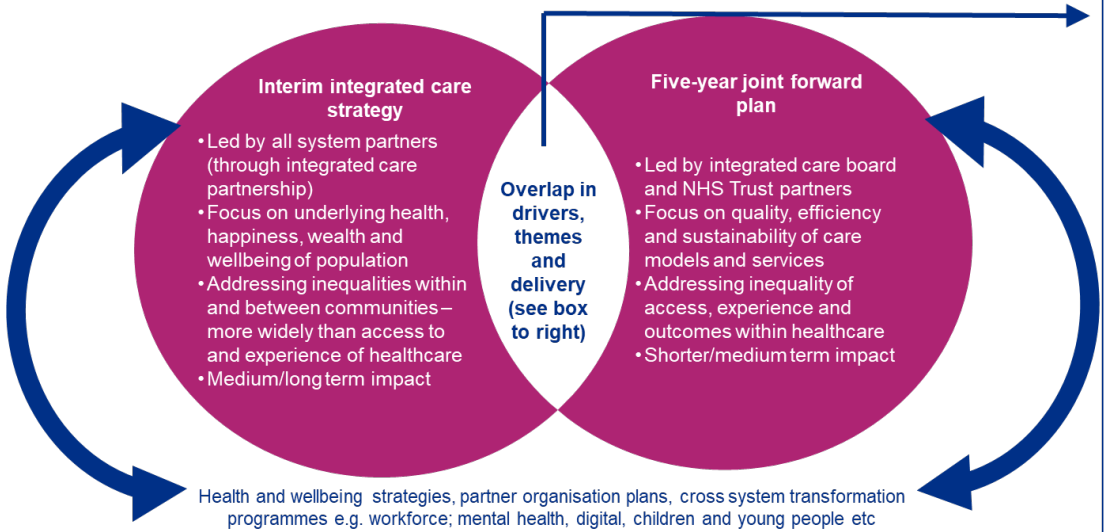
Implementation and iteration

The integrated care partnership strategy is informed by other local strategies and plan, and in turn informs the refresh of those strategies and plans over time. This is an iterative process and joining up the priority areas across our various strategies and plans forms part of our new ways of working together.
We will regularly review our priorities to ensure that they remain relevant and check that we are delivering improvements in these areas for our local communities. In particular, we will refresh our strategy when new joint strategic needs assessments are created.

During the early part of 2023, we will:

- Publish a summary version of our interim strategy
- Invite further reflections and feedback from local people and partners to further inform our next work together to translate this strategy into delivery, as well as future refreshes of this strategy
- Work together and with local people, especially those with lived experience, to
    - develop our delivery framework for each of our priority areas
    - create a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability
    - establish effective ways of reflecting on, and learning from our work together as a 'learning system'
    - use this interim strategy to inform the development of the NHS five-year joint forward plan (see right), and inform future versions of individual health and wellbeing strategies, NHS, voluntary sector and other organisation-specific plans

If you would like to be involved in these activities, please contact hiowicb-hsi.partnerships@nhs.net



Areas of overlap

- Both deliver the four aims of the ICS
- Both aim to address the most critical issues affecting the health service – i.e. increasing demand for services, workforce shortages. The strategy does this through the lens of population wellness, and the joint forward plan through the lens of service sustainability and quality.
- Both require a wide range of partners to be involved in delivery
- Both require community involvement and co-production
- The interim integrated care strategy and the joint forward plan together provide the strategic priorities and direction for the integrated care board.

Our strategy in summary

Our shared aims	Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development.
Our challenges	Our population is growing and ageing. Improvement in life expectancy has stalled and begun to fall. Vulnerable people are dying younger and suffering poorer health than the general population. Inequalities are getting worse and drive worse outcomes. Challenges in workforce supply, funding, demand for services outstripping supply, impact of Covid-19 and cost of living. Without check inequalities will grow, years lived in poor health will increase and services will not cope.			
A radically different approach	Working together across all partners to take a community-centred approach to wellbeing. Seizing the opportunities offered by working together as a system and partnership with a mandate to use collective resources in new and different ways to build a better future - health, happiness, wealth and wellbeing.			
Priority areas *These themes emerged from evidence and conversations in Hampshire and Isle of Wight*	**Children and young people** We want all children to get the best possible start in life, regardless of where they are born.	**Mental wellbeing** We want mental wellbeing to be at the forefront of all that we do and to ensure as much importance is given to mental wellbeing as physical health.	**Good health and proactive care** We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities.	
What we will initially focus on together *In our work together to deliver on our priority areas, we will:*	**Focus on the "best start in life" for every child** in the first 1000 days of their life	**Better connect people** to avoid loneliness and social isolation	Improve **social connectedness**	
	Improve access and mental health outcomes for children and adolescent mental health services	**Promote emotional wellbeing and prevent psychological harm**	**Provide support in community settings** for healthy behaviours and mental wellbeing	
	Work with schools and other key partners on **prevention and early intervention**	**Improve mental health and emotional resilience for children and young people**	Ensure **equal importance** is given to mental wellbeing and physical health	
	Continue and develop our **trauma-informed approach**	Focused work to **prevent suicide**	Minimise potential health and wellbeing impact of **cost of living pressures**	
	Co-locate services to enable a **family-based approach**	Improve access to **bereavement support**	Provide **proactive, integrated care for people with complex needs**	
	Further develop a **joint children's digital strategy**	**Address inequalities in access and services**	Support **healthy ageing** and people living with the impact of ageing	
		Support the **mental health and wellbeing of our staff**	**Combine resources** around groups of greatest need	
Enabling priorities *Improving workforce, digital, data and shared insights will enable us to deliver our work together around children and young people, mental well being and promoting good health.*	**Our people (workforce):** We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .	**Evolve our workforce models and building capacity to meet demand**	**Ensure the availability of the right skills and capabilities**	**Ensure people who provide services are well supported and feel valued**
	Digital solutions, data and insights: We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income	**Empower people to use digital solutions**	**Support our workforce**	**Improve how we share information**
				Continue to improve our digital solutions
The "Hampshire and Isle of Wight way"	**As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership:** working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.			

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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.

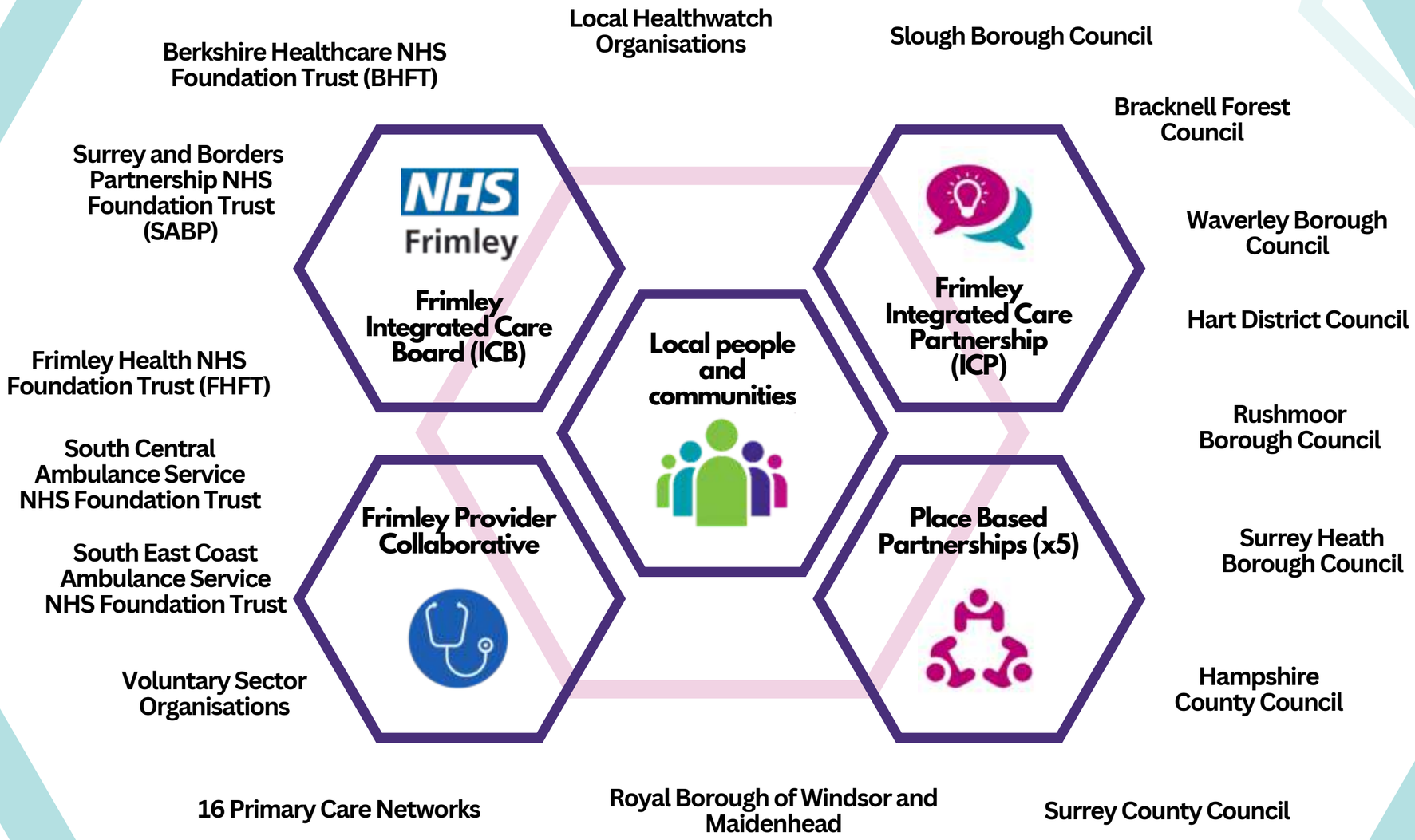
Our partnership, comprised of dozens of Public Sector and VCSE organisations, is led by committed clinical and professional leaders. We have been working together since 2016 when our very first partnership plan was published which set out our aspiration to unlock the benefits of greater partnership working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

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

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

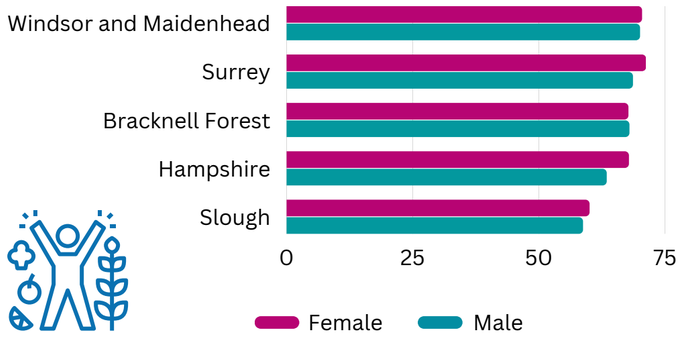
Life expectancy	81	84
Healthy life expectancy	66.8	67.4

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

Healthy life expectancy at birth



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%

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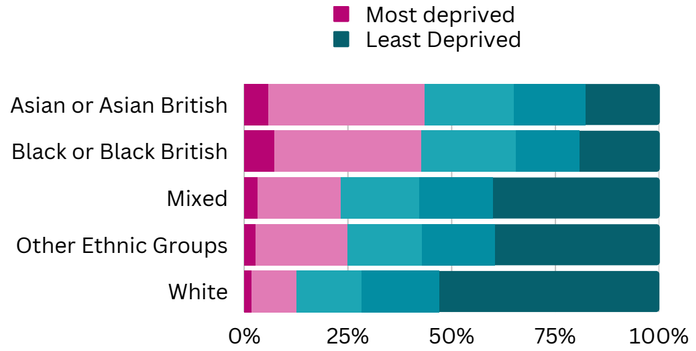
Frimley population insights: wider determinants of health

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**

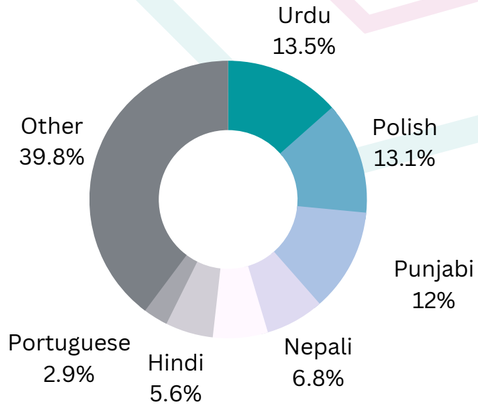
These patients are living in deprived areas and poorly insulated homes

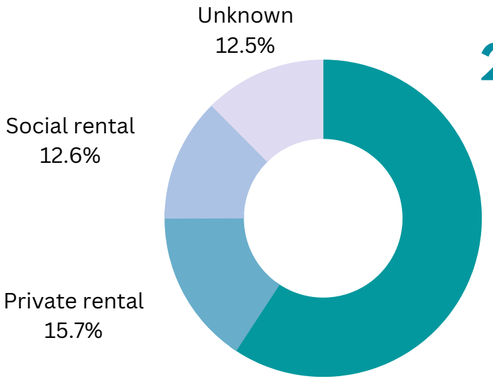
1.4% (700) have significant health issues
17.1% (9,500) have moderate health issues
76.5% (43,000) are generally healthy

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

5.8% of the population have a BMI over 35

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.

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

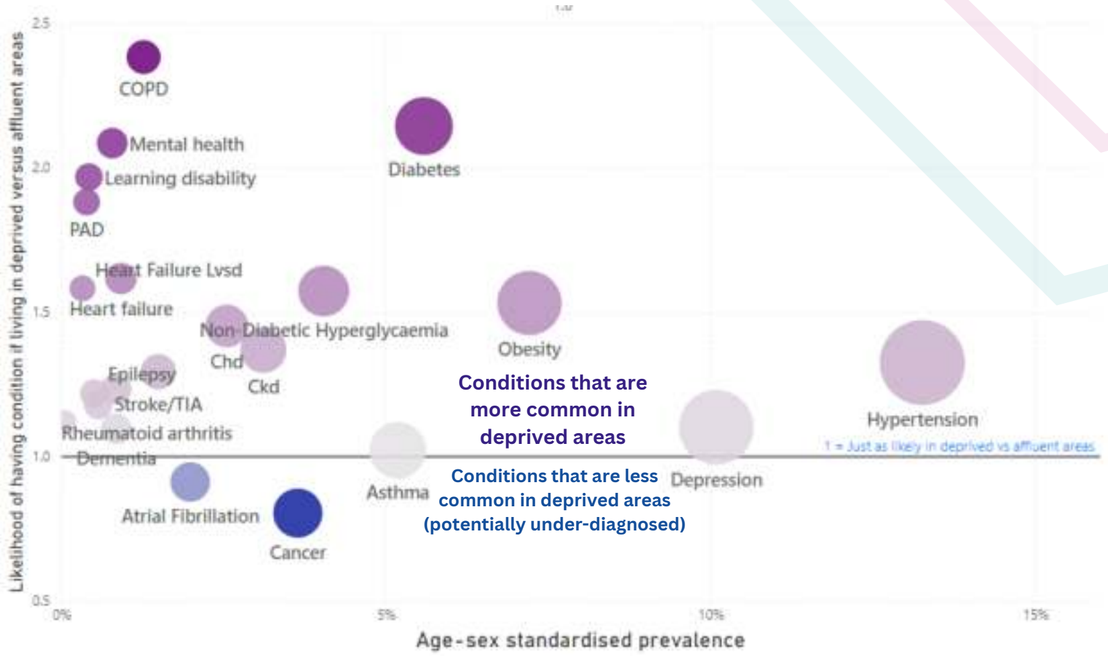
When looking at **ethnicity data** we notice the following:

- 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

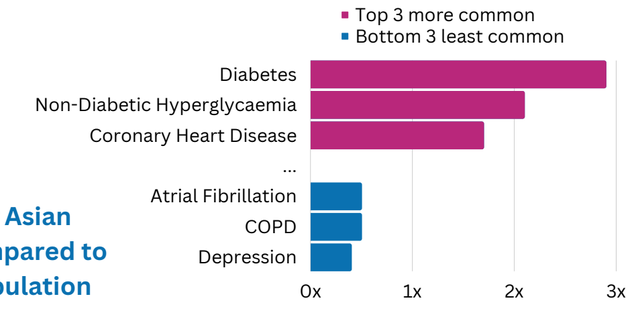
Slough compared to other parts of the system is **younger, higher % BAME, more densely populated** and **multigenerational households** and **more deprived.**

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.

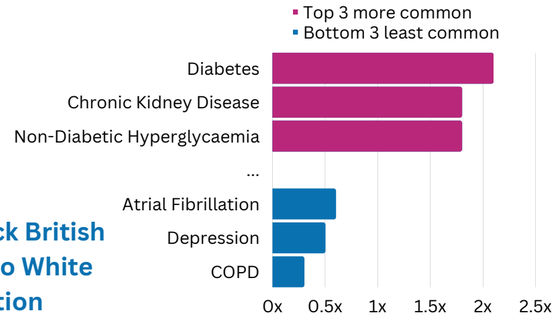
Increased prevalence of chronic diseases lead to **health inequalities** as well as disproportionate risk of impact from community transmitted conditions such as Covid-19.



Asian or Asian British compared to White population



Black or Black British compared to White population



Frimley population insights: cancer, diabetes, hypertension

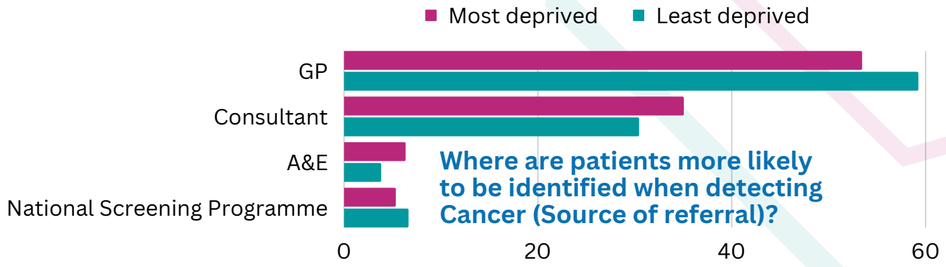
Those in the most deprived population have a lower percentage of **cancer referrals** made from all sources including National Screening programs and GPs, compared to the least deprived population (quintile 5). A greater percentage of diagnosed cancers are referred from Consultants or AE departments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

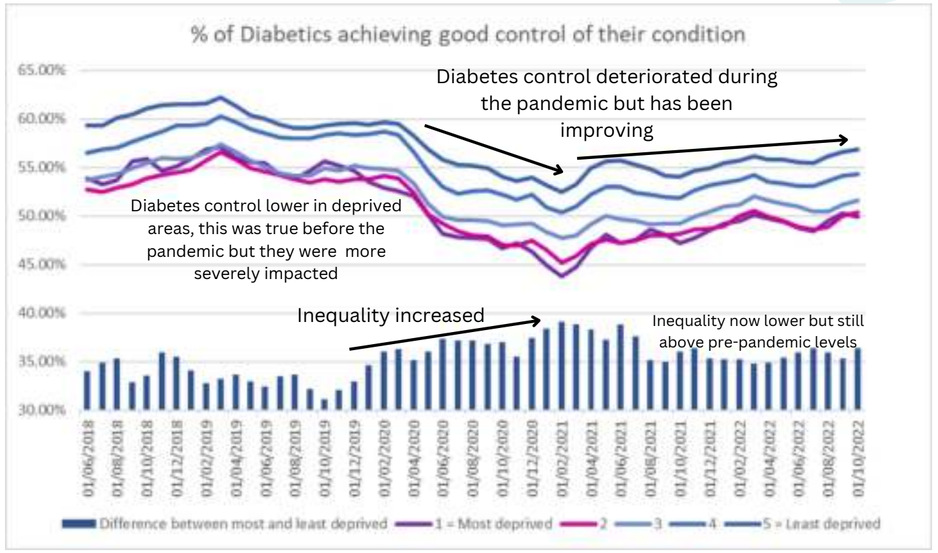
Control of **Diabetes**, however, in the Core 20 population deteriorated the most during the first year of the pandemic. The proportion of patients with **HBA1C** <=58 fell from 61.2% in Nov 2019 to 57.4% in Nov 2020. It is now improving but still below pre-pandemic levels.

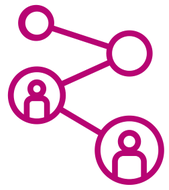
This deterioration was not seen as strongly in the least deprived population, and we now have a larger variation in control of diabetes compared to pre-pandemic.

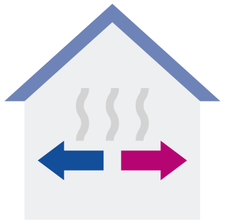
In Frimley, we have been very focused on **improving detection, monitoring and treatment** of hypertension and diabetes. By utilising a wide range of local innovations we have seen a very encouraging return to growth in achievement of these indicators in Summer 2022.



Where are patients more likely to be identified when detecting Cancer (Source of referral)?







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

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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).

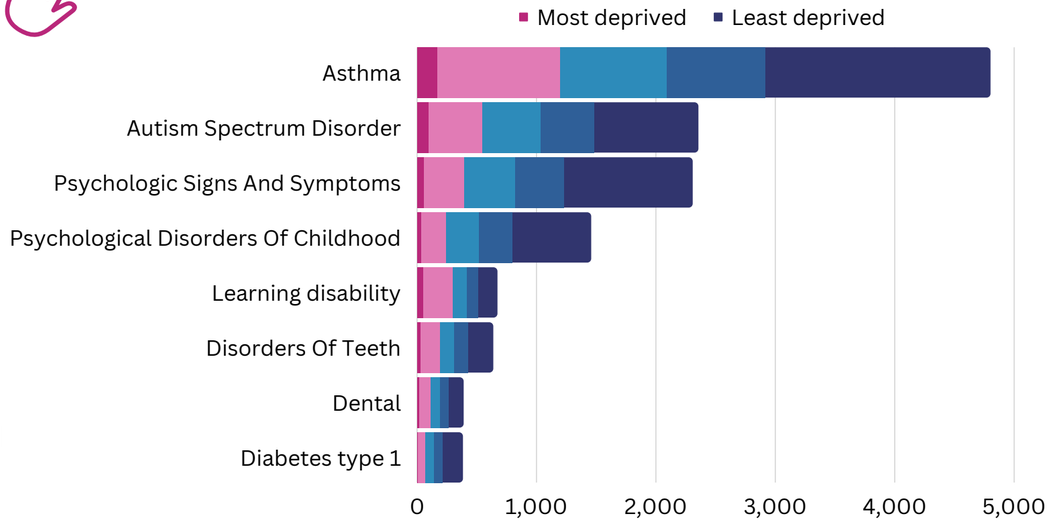
There will be a joined up leadership approach across local authorities voluntary sector and health, connected with places to share initiatives and good practice. Our collaborative endeavour will enable consideration of options to optimise and support public health nursing workforce.

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

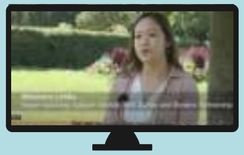
Frimley Health and Care ICS has a strong reputation for working with people and communities, built on trust and long standing partnership work with a wide range of stakeholders. We recognise that insight underpins and supports transformation. Delivery models are changing, and public involvement is essential. 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 – Wavelength Cohort One

2019 – Using insights in our design

Refocus

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



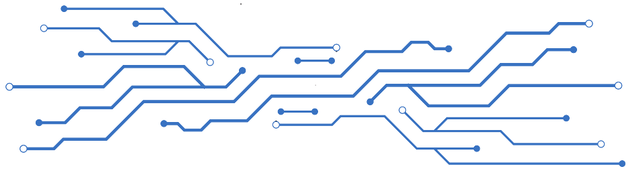
Achievements

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.

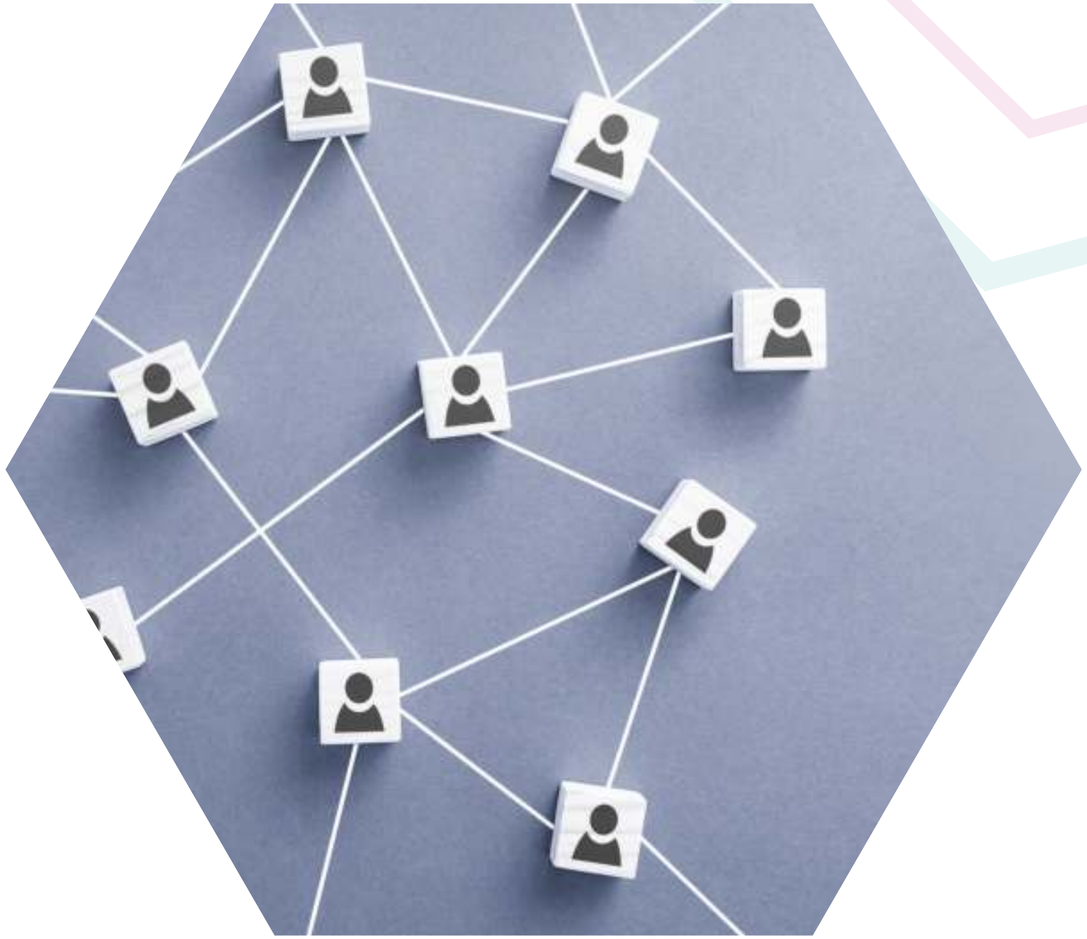
insight.frimleyhealthandcare.org.uk/strategyrefresh

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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Summary of the two Integrated Care Strategies of Hampshire and Isle of Wight ICS and Frimley ICS

Ros Hartley – Director of Partnerships, Hampshire and IOW ICS
Sam Burrows – Chief Transformation & Digital Officer, Frimley ICS

2 March 2023




Update on Integrated Care Strategy and Partnership

Our partners involved

Hampshire and Isle of Wight

Progress to date

July- September 2022

Developed our Strategic priorities in partnership

September – December 2022

Developed the strategy based on our strategic priorities and engaged across the system

January 2023

Looked in detail at 3/5 the strategic priorities to identify the opportunities to deliver in partnership

February- May 2023

Look in detail at the other 2 priorities

Determine what we deliver under each priority and our delivery approach and how we will measure success

May -June 2023

Socialisation, sign off and submission of the Joint Forward plan

Hampshire and Isle of Wight

OUR STRATEGY ON A PAGE

OUR 5 PRIORITIES AND KEY AREAS OF FOCUS:

POPULATION OF 1.9M:

- Varied demographics
- Areas of deprivation
- Variation in life expectancy
- Strong partnership working to seize opportunities

Children and young people

- Continue and develop our **trauma-informed approach**
- Co-locate services to enable a **family-based approach**
- Further develop a **joint children's digital strategy**
- Focus on the **"best start in life" for every child** in the first 1000 days of their life
- Improve **access and mental health outcomes** for children and adolescent mental health services
- Work with schools and other key partners on **prevention and early intervention**

Mental wellbeing

- Improve access to **bereavement support**
- **Address inequalities** in access and services
- Support the **mental health and wellbeing of our staff.**
- Better connect people to **avoid loneliness and social isolation**
- Promote **emotional wellbeing** and **prevent psychological harm**
- Improve mental health and emotional resilience for **children and young people**
- Focused work to **prevent suicide**

Good health and proactive care

- **Improve social connectedness**
- Provide **support in community settings** for healthy behaviours and mental wellbeing
- Ensure **equal importance** is given to mental wellbeing and physical health
- Minimise potential health and wellbeing **impact of cost of living pressures**
- Provide **proactive, integrated care for people with complex needs**
- Support **healthy ageing** and people living with the impact of ageing
- Combine resources around **groups of greatest need**

Our people (workforce)

- Evolve our **workforce models** and building **capacity to meet demand**
- Ensure the availability of the **right skills and capabilities**
- Ensure people who provide services are **well supported and feel valued**

Digital and data

- **Empower people** to use digital solutions
- Support our **workforce**
- **Joint** data, information and **insights**
- Improve how we **share information**
- Continue to improve our **digital solutions**

What's been achieved

- 2 system wide events – over 200 people attended
- A statutory Joint Committee designed and being established
- Priorities agreed for our Integrated Care Strategy and supported by all partners which focus on improving the wellbeing and outcomes for our local people
- Enthusiasm and commitment to build on what we have and work in partnership to take further
- Vision statement being finalised
- Charter of Behaviours being finalised
- Delivery in partnership linking to Operating Plan and Joint Forward plan

Example actions to progress

1. **Children and Young People** –
   - Awareness campaign across the system building on the first 1000 days

2. **Mental Wellbeing –**
   - Hold a community conversation targeting those underserved communities with joint targeted action across the system on World Mental Health day
   - Align messages across the system with clear succinct coordinated comms even if delivered locally

3. **Good health and proactive Care –**
   - Establish a community of practice to take this forward
   - Map social prescribers and link community data to medical data

4. **Digital & Data Insights** –
   - Set up a partnership assembly/ lunch meeting that is specific to data and digital.
   - Utilise the success of the Population Health Management data sharing agreement as a comms piece across partnerships.

Next steps

Informing the NHS Joint Forward Plan

- Define the key deliverables for the Integrated Care Partnership for the next 12 months and longer term informed from the 8th February assembly
- Define the ways in which the system will measure success and the impact the proposed changes will have

Further developing the Integrated Care Partnership

- Develop the partnership vision and behaviours to test with the ICP joint committee
- Define the next steps for the ICP assembly and the development of the integrated care partnership

Ensuring delivery against our strategic priorities

- Identify or establish the forums /programmes where the key deliverables will be taken forward and ensure the right membership
- Establish and refine the governance to support the delivery of the work including the Integrated Care Partnership Joint Committee and any supporting structures

Frimley Health and Care

NHS
Frimley

Update on ICS Strategy

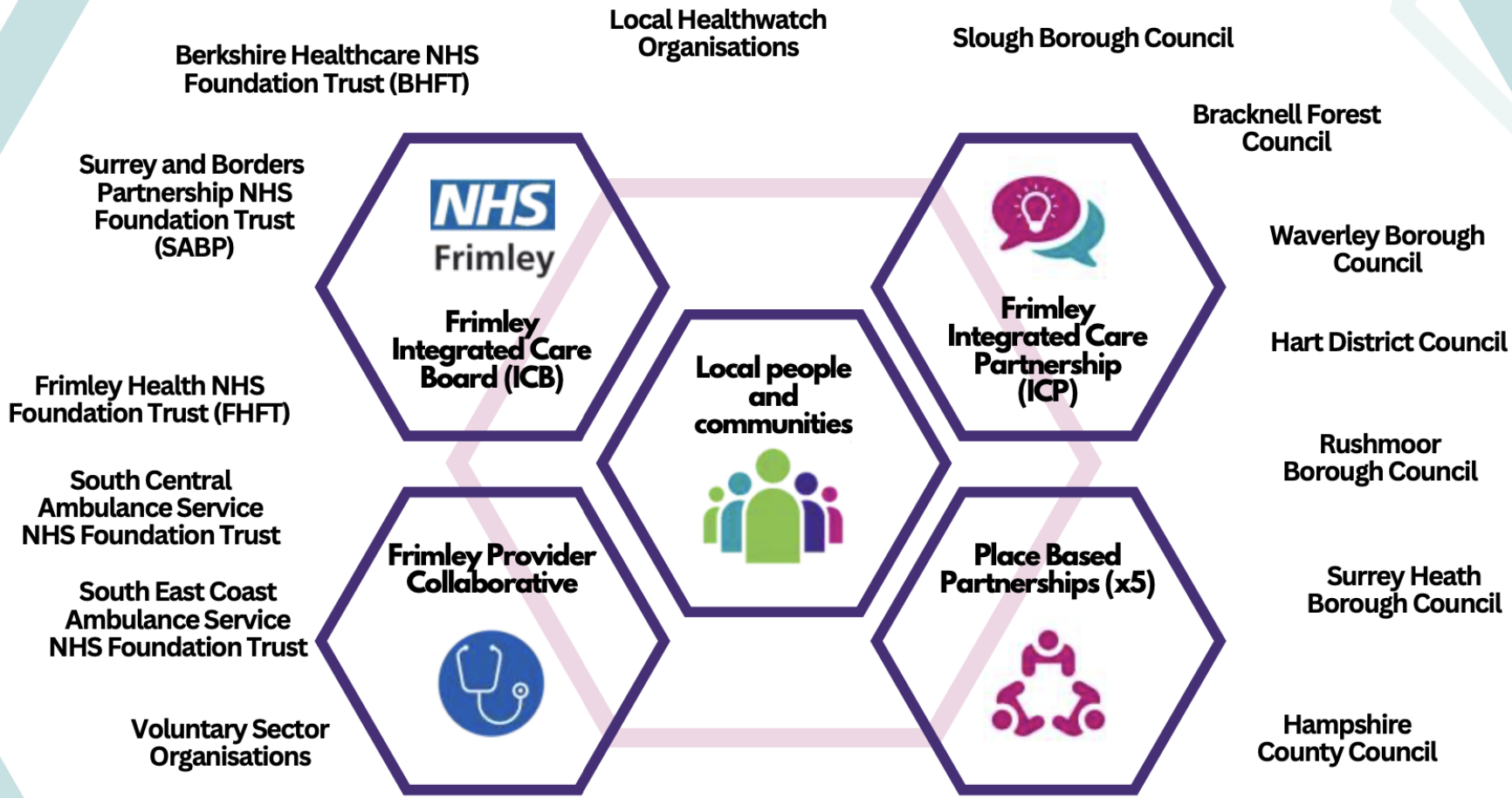
Hampshire Health & Wellbeing Board

2nd March 2023

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

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.

The Integrated Care Partnership is now leading and overseeing a review and refresh of our 2019 strategy in order to ensure it is fit for purpose in the next period ahead.

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.

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, including the ICB Board. 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.

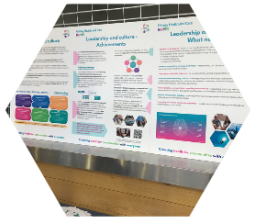
Partnership engagement

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 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

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 v experience deprivation and poverty across our communities, including the newly published Core20PLUS framework for children.
- Babies and Children in the first 1001 days through to primary school, ensuring that every child is "school 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)

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

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.

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.

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.

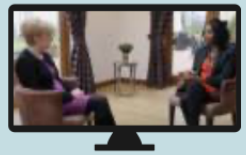
Alliance and coalition building will create a more permissive environment of collaborative networks and adaptive partnerships and link with the systems other ambitions and programmes (e.g. children and young people)

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



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.

Frimley Health and Care

Hampshire and Isle of Wight

Conclusions

- Both strategies have been developed in partnership with local authorities; the Joint Strategic Needs Assessment and Health and Wellbeing Strategy for Hampshire
- Both strategies have been developed with a broad range of stakeholders and set out the aspiration to unlock the benefits of greater partnership working and using the collective resources more effectively to improve the health of the population.
- Both strategies place an emphasis on the importance of working better with children and families, as well as supporting people to live healthy lives with an emphasis on preventative interventions to reduce the need for health and care services in the long term.
- Both systems recognise the need to review their workforce models to build capacity and ensure the right skills and capabilities are there for the future. The importance of investing in digital solutions and sharing capacity across the partnerships also come through as themes
- Both strategies build on and support the work ongoing at a Hampshire place level. To ensure the effective delivery of the strategy, it is recognised that partnership working with the Health and Wellbeing Board will be vital.

Questions?

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Wellbeing Board
Date:	2 March 2023
Title:	Ageing Well Update - Theme Focus
Report From:	Director of Adults' Health and Care

Contact name: Graham Allen

Tel: 03707 795574 **Email:** graham.allen@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to provide an update to the Health and Wellbeing Board on the priorities and progress on the Ageing Well chapter of the Hampshire Health and Wellbeing Board Strategy. The presentation highlights key areas of progress across older adults' health and care, digital and technology and public health programmes.

Recommendations

2. That the Hampshire Health and Wellbeing Board:
    a. Note the progress on 'Ageing Well' partnership working over the last year and future plans.
    b. Note the increasing demand arising and the complexity of our ageing Older Adults in general.
    c. Support the launch of Live Longer Better programme communities of practice.
    d. Note the variety of approaches across use of technology and partnership working to provide choices for older people in need of care and support to help them age well and maintain independence.

Executive Summary

3. Each chapter of the Hampshire Health and Wellbeing Strategy is underpinned by priorities and a business plan summarises planned areas for focus. Building on the Board's recent Annual Report, the presentation accompanying this report outlines recent progress and future development in the Ageing Well theme area.

Consultation and Equalities

4. This is a progress update. Consultation and equality impact assessment work has not therefore been needed.

Co-Production

5. The Hampshire Older Adults Partnership forum is in development, with the first meeting on 27th February 2023. The purpose of the forum is to engage directly with service users, and terms of reference will be developed with the group at the first meeting.
6. Insights and engagement work has been instrumental in the development of plans for the Live Longer Better programme, including insights work with residents (strength and balance and continence, website development) and also through collaboration with health and care providers (extra care programme, steady and strong programme).

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

   The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

   - Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
   - Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
   - Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

   Due regard in this context involves having due regard in particular to:

   - The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
   - Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
   - Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

   This is a progress update to the Board; therefore an equalities impact assessment has not been completed.

Health and Wellbeing Strategy

Ageing Well Update

02 March 2023

Contents

HWB Strategy: 2019-2024
Ageing Well priorities – remain consistently focussed as our operating context changes

1. Continue to develop connected communities which can support people to live happy, healthy lives in the place of their choosing
2. Enable people to plan for a fulfilling, purposeful older age
3. Create healthy home environments which allow people to stay well and independent into older age
4. Enable people to lead healthy, active lives

The outcomes we want for Older Adults – part of Ageing Well 2023 and be cognisant of the lasting impacts of Covid

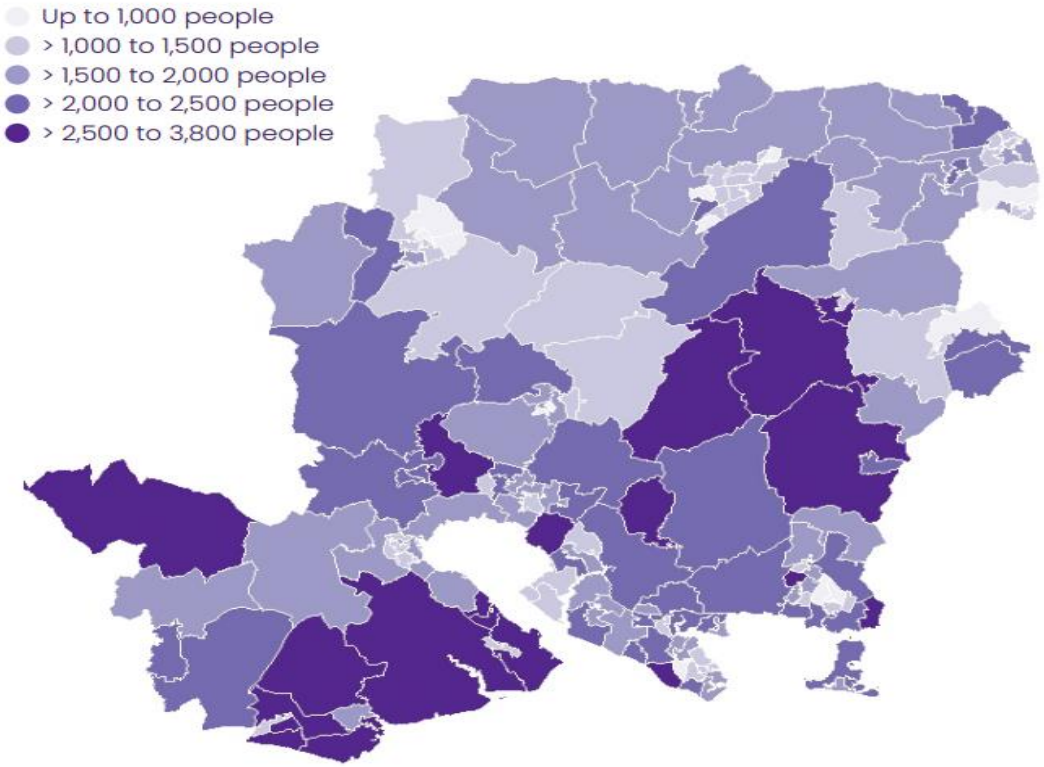
- ✓ Independence and wellbeing is maximised
- ✓ Choice over services with self service where we can
- ✓ Access to places and services that help to promote wellbeing and keep clients connected to those surroundings and networks that they may call home
- ✓ Access to professional, caring and experienced social care, business support and Reablement teams and employment opportunities
- ✓ Reduced inequalities and increased inclusion
- ✓ Kept safe, kept well

Demand for our services and complexity in ageing - continue to grow.

Number of people aged 65 years and over (2021)

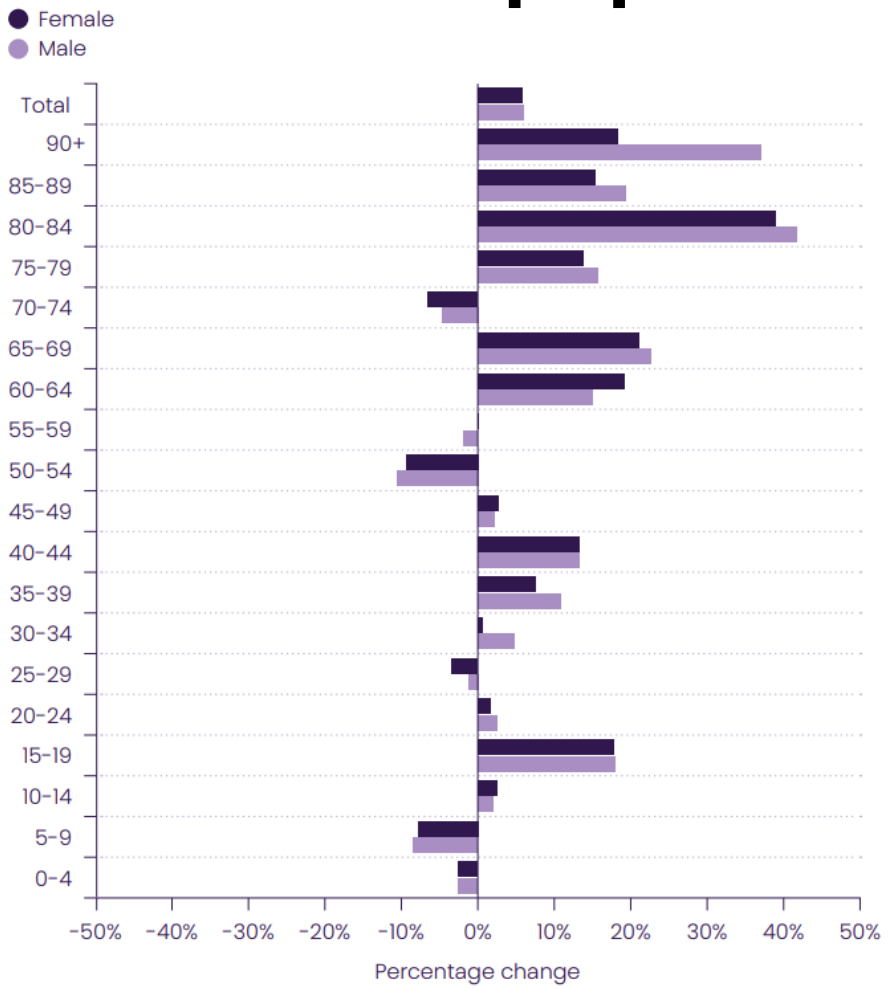
317,080
65+ year olds in Hampshire

22.3%
of the total population are aged 65+



Source: JSNA Demography updated 2023

Hampshire population percentage change between 2021 and 2028 population forecasts



Source: JSNA Demography

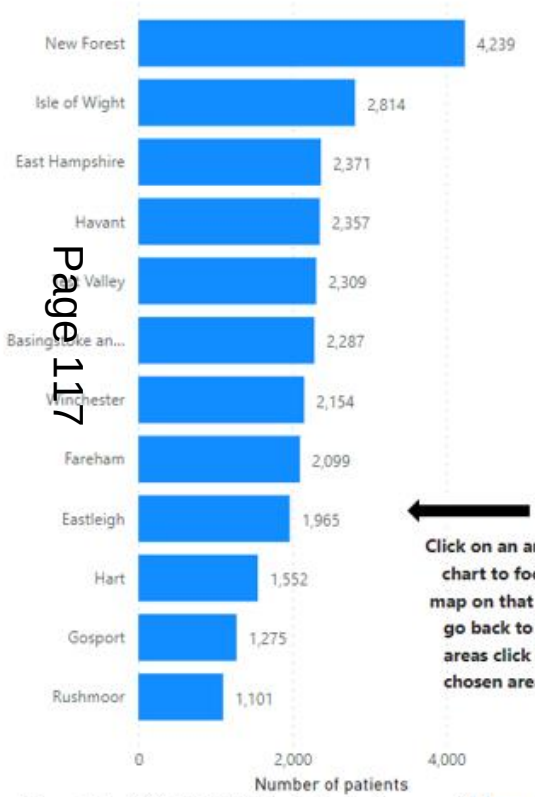
Dementia by area – increasing

Older people (aged 65+)

Data source: Various (see data sources sheet)

Moderate or severe frailty | Reduced mobility | Urinary incontinence | Some hearing loss | Severe hearing loss | Moderate or severe sight loss | People experiencing falls | **Dementia (estimated)**

Number of people with Dementia (estimated) by area



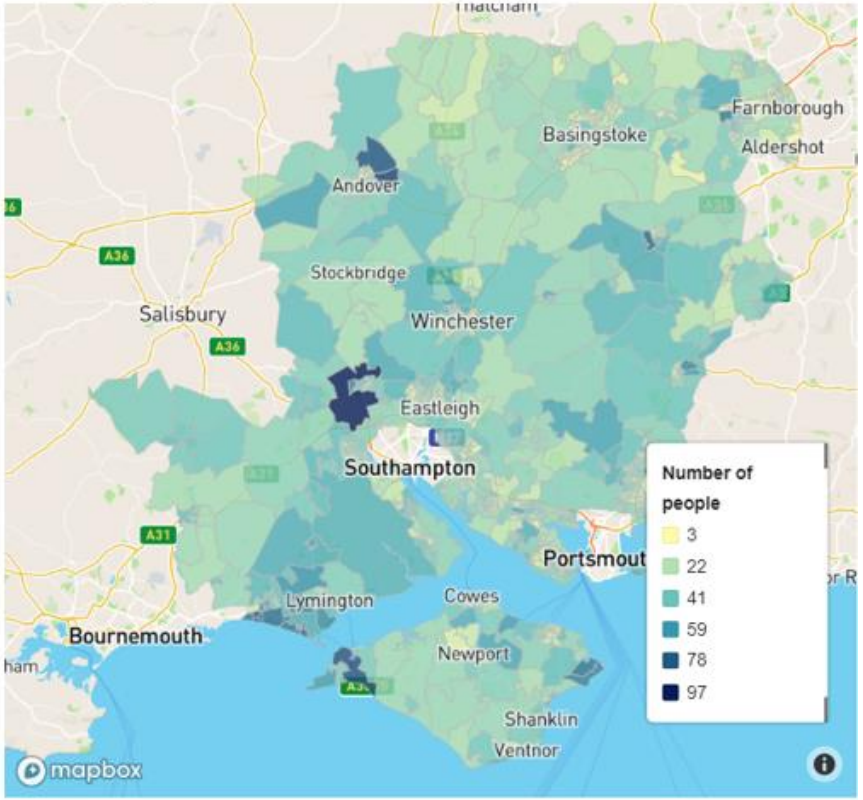
Prevalence of Dementia (estimated) by district

Area	People	Prevalence
Basingstoke and Deane	2,287	6.8%
East Hampshire	2,371	7.7%
Eastleigh	1,965	7.1%
Fareham	2,099	7.5%
Gosport	1,275	7.3%
Hart	1,552	7.5%
Havant	2,357	7.6%
New Forest	4,239	8.0%
Rushmoor	1,101	6.9%
Test Valley	2,309	7.4%
Winchester	2,154	7.7%
Total	**23,710**	**7.5%**

Area	People	Prevalence
Isle of Wight	2,814	6.9%

Click on an area in the chart to focus the map on that area. To go back to see all areas click on the chosen area again

Number of people with Dementia (estimated) by LSOA



Hampshire and Isle of Wight Joint Strategic Needs Assessment Microsoft Power BI

Data includes estimates for each condition for the resident 65 and over population.

Flu and COVID-19 Vaccinations

Autumn COVID-19 booster campaign

As of 8th February 2023, 78.4% of people over 50 years in Hampshire had received an autumn booster. (England average 64.7%)

Data source: Coronavirus in the UK dashboard

Influenza Vaccination 22/23 season

As of 31st December:

	HIOW	Frimley	England
Over 65s	82.5%	78.6%	78.4%
Under 65 adults (at-risk)	52.9 %	49.3%	46.3%

Source of data: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 - GOV.UK (www.gov.uk)

Approaches: Digital Inclusion & Partnership Working

- Supporting older people to become **digitally enabled (DE)** brings a variety of benefits, e.g. helping people to access services and remain socially connected
- **HCC's Demand Management and Prevention Team** continue to work with ICB and VCSE partners in addressing Digital Inclusion in South East Hampshire. Work includes expanding 'digital champions' schemes in partnership with the Good Things Foundation and bringing together a network of organisations to share intelligence and good practice.
- Many local **voluntary and community** organisations have moved into the DE arena to support adults no longer able to access their face-to-face services. The HCC Infrastructure Grant funding to the Hampshire CVS has a priority to develop **creative digital responses** to support health and social care. This has included supporting the establishment of another two digital inclusion projects, and to support existing projects such as the Reboot IT (IT equipment recycling) and IT support for over 55s.
- HCC is working with Gosport Borough Council on the development of the Gosport Digital Peninsula Strategy, which has a priority to support Digital Inclusion, supported by the £1m UK Shared Prosperity Fund allocation to the area over the next 3 years.
- Greater focus on 'Digital Shift/Switch' and the implications across Hampshire, TEC data integration, digital platforms and broader technical opportunities
- Opportunity for developing Digital landscape and initiatives with the NHS to cross the boundaries using tech and digital platforms where there are common areas of interest and Integrated Working including
  - Ageing Well
  - Anticipatory Care
  - Urgent Care Response
  - Potential for Direct Referral Routes into TEC e.g. Falls Care, Delirium Pathway
  - Dementia services
  - Supporting Carers to care longer and avoid escalation to secondary care
- Key HCC contact for ongoing engagement is Mark Allen, Head of Digital and TEC mark.allen@hants.gov.uk

HCC Care Technology Programme

- Partnership with PA Consulting – the Argenti Partnership
- Significant impact on Social Care practice and delivery
  - 37,000 referrals since 2013
  - Over 14,000 people currently supported to live at home
    - Either with just Care Technology or alongside Home Care
- Over £19m social care cost benefits identified over 9 years
- Innovative platform – Use of Consumer Devices (Amazon Alexa), Support to Carers, Short-term services from Hospital Discharge (RDS, D2A), development of the Automated Call System (ACS)

Approaches: Live Longer Better programme

The Hampshire Live Longer Better programme is part of a national revolution by Sir Muir Gray and led locally by Public Health, Demand Management & Prevention and Energise Me. The primary aim of the programme is to increase the levels of physical activity in older people, thereby improving quality of life and healthy life expectancy and enabling the older population in Hampshire to live more independently for longer (decreasing or delaying care needs).

There are 3 strands to our work in Live Longer Better:

Communities of Practice: We are developing communities of practice which will involve partners from district and borough councils, health, voluntary sector and adult health and social care, who will champion the programme in local areas. Each community of practice will develop an implementation group and a localised action plan within the parameters of the Hampshire Live Longer Better programme.

General over 65s programme: This aims to understand barriers and facilitators to physical activity in older people and utilise this through the community of practice and social marketing to increase physical activity among this group. Progress has included creation of a website, insights with local communities in strength and balance and continence, and developing an offer for over 65s with local leisure centres.

Adult Social Care programme: Adult social care work with large numbers of older people at key touch points where behaviour change may be more likely. We have been focussing on workforce development and growing opportunities for older people to be more active in social care settings (including extra care).

The Hampshire Assembly on the 2nd March 2023 has a focus on older people's health and wellbeing and will be used to launch the communities of practice.

Approaches: Falls Prevention

Key aspects of Hampshire County Council's falls prevention programme include Steady and Strong classes and Falls Friends champion training.

Ambitions in 23/24 include:

- Continuing to grow the Steady and Strong programme (currently over 90 classes available). This includes online options.
- Expanding the Steady and Strong Dance offer, in collaboration with an academic partner to support evaluation.
- Developing an offer to upskill TEC installers and responders to support falls prevention opportunities.
- Launching a falls prevention checklist for the public and professionals
- Working with NHS on extending initiatives such as the falls car (Fire and Rescue and NHS funded).

Approaches: Proactive Enhanced Care (PEC) Case Holding

The Proactive Approach: how it works

Analysis of Domiciliary care provisions showed that the **85+ age group** accounted for **approximately half of new** Dom care provisions and their care packages **double every year** in their first 2 years.

- The PEC approach in a nutshell:
  - New individuals from the key over 85 demographic are **allocated as soon as possible**.
  - **For the first 12 weeks practitioners repeatedly contact individuals**, working with Health and Community resources aiming to stabilise and prevent further loss of independence.
  - This repeated contact helps **build rapport and trust** with the individual/their family. We have found building rapport and trust has made it more likely that people will accept services that they might have refused initially, this is important.
  - Frequent checkpoints with individuals **continuously monitor progression of their needs** especially using the **frailty scale**. The richer a picture that is built of people's needs, the better our ability to **predict** when **pre-emptive** intervention could get support in before needs escalate. Some findings have shown the original frailty score is lower than the exit score, getting to know an individual gives us the opportunity to have better clarity on an assessment.
  - The Practitioner should not end their involvement with the individual earlier than 20 weeks; unless the individual has moved into a long-term service, they have passed away or there are exceptional circumstances such as their physical needs are now too high (frailty score 8-9) or their cognitive/behavioural needs are now too high.

16% of individuals have greater stability when existing the PEC process after 20 weeks

Proactive case holding | Predicted need increase | Pre-emptive intervention | Preventive care increase

Recommendations

HWB Board are asked to:

- Note the progress on Ageing Well through partnership working over the last year and plans to adapt and recover after Covid-19
- Note the increasing demand arising and the complexity of our ageing, older adults
- Support the launch of Live Longer Better programme communities of practice
- Note the variety of approaches - including the use of technology and partnership to provide choices for older people in need of care and support to help them age well and maintain independence

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Wellbeing Board
Date:	2 March 2023
Title:	Smokefree Hampshire 2030 – Achieving a smokefree generation for Hampshire by 2030
Report From:	Director of Public Health

Contact name: Fatima Ndanusa, Public Health Principal

Tel: 07704018652 **Email:** Fatima.ndanusa@hants.gov.uk

Purpose of this Report

1. The purpose of this report is to provide an update to the Hampshire Health and Wellbeing Board on the refreshed Tobacco Control Strategy for Hampshire. The purpose of the strategy is to outline Hampshire's roadmap to achieving Smokefree status by 2030.

Recommendations

That the Health and Wellbeing Board:

2. Note and support the refreshed Tobacco Control Strategy for Hampshire - Smokefree 2030

3. Support action to deliver on the Smokefree Hampshire 2030 strategic priorities, including building strong place-based partnerships to achieve our Smokefree ambition.

Executive Summary

4. This report seeks to provide an update to the Hampshire Health and Wellbeing Board on the newly refreshed Hampshire Tobacco Control Strategy – Smokefree Hampshire 2030.

   The purpose of the strategy is to drive clear and consistent action to end smoking in Hampshire – this is considered to be a situation in which less than 5% of the Hampshire Adult Population are recorded as smokers.

The strategy aims to provide an evidence-informed framework for action, to support partners working to promote smokefree communities, to help Hampshire adult smokers to stop smoking and to support action to prevent young people from starting to smoke.

Next steps are to:

- Reinvigorate and embed the Hampshire Tobacco Control Alliance as a key mechanism for delivering the Hampshire tobacco control strategy.
- Continue to encourage more smokers to quit, highlighting the free and expert led support available, continue to promote smokefree communities and reduce uptake in young people
- Continue to update the Health and wellbeing Board on progress to successfully achieve Smokefree Hampshire 2030 via this strategy.

Contextual Information

5. Smoking is the biggest cause of preventable deaths and disease in Hampshire and a key driver of health inequalities.

6. This refreshed strategy - Smokefree Hampshire 2030, builds on the previous Hampshire Tobacco Control Strategy – A smokefree generation for Hamsphire 2018-2021.

7. The strategy aims to achieve a smokefree generation by focusing on reducing smoking related health inequalities by helping those most impacted by smoking in Hampshire to become smokefree.

8. The implementation of this strategy will have a stronger emphasis on place-based working to reduce the Hampshire smoking prevalence, including working closely with in partnership across Hampshire communities.

Hampshire Health and Wellbeing Board

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	Yes
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	Yes
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation).
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it.
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic.
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

2.1 An equalities impact assessment has not been completed for this item which is an update.

Smokefree Hampshire 2030 – a tobacco control strategy to end smoking in Hampshire

Hampshire County Council

Hampshire Health and Wellbeing Board

Content

- Hampshire Tobacco Control Strategy
- Vision, purpose, strategic priorities
- Alignment with Hampshire Health and Wellbeing Board and Integrated Care strategic priorities
- Hampshire Tobacco Control Alliance
- Successes and next steps

Smokefree Hampshire 2030 why we must act

1

Smoking is the biggest cause of **preventable deaths** and key driver of **health inequalities** in Hampshire.

2

Young people growing up in a smoking household are **four times** more likely to start smoking.

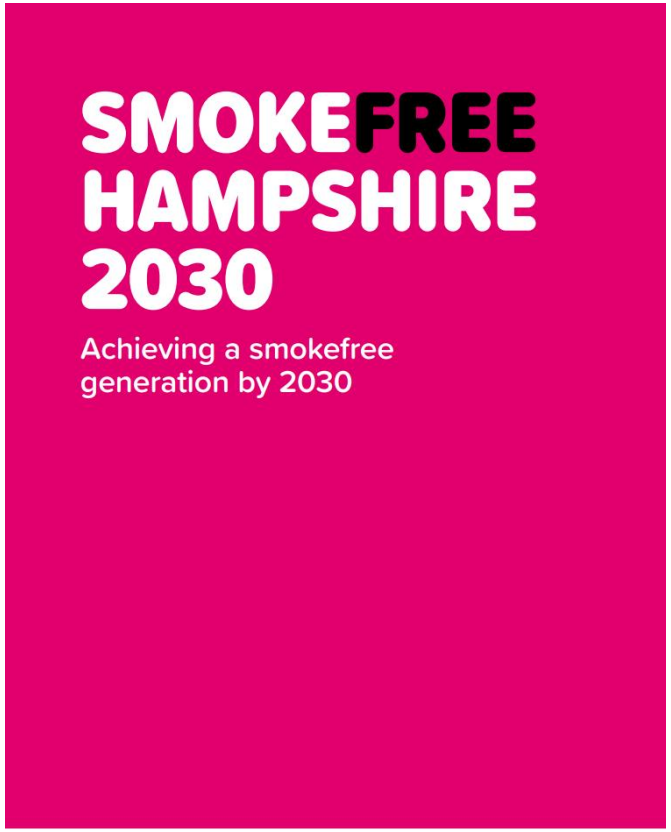
3

Mothers under the age of 20 are **four times as likely** to smoke throughout pregnancy compared to those **aged 35 or over**.

4

Smoking is the biggest driver of the **10-20-year life expectancy gap** for those with **mental health conditions**.

Smokefree Hampshire 2030
Purpose and aim of the strategy



ROADMAP TO 2030

FRAMEWORK FOR ACTION

CLEAR AND CONSISTENT ACTION

Vision

"Our **vision** is to create a Smokefree Hampshire, where all residents are free from the **health**, **economic** and **environmental** harms caused by tobacco"

Strategic Priorities

Helping smokers to stop

We will work with our NHS and Community partners to:

- help smokers in our most disadvantaged communities to stop.
- support all pregnant women and their partners to stop.
- support embedding smoking cessation into patient pathways via NHS Long Term Plan.

Promoting Smokefree communities

We will ensure that people are protected from second-hand smoke and illegal tobacco by:

- supporting communities to make a smokefree environment the norm, using approaches such as campaigns and advocacy.
- working with a variety of partners to promote smokefree pregnancies, homes and key settings.

Preventing smoking uptake in young people

We will continue to support organisations already working with young people to prevent the uptake of smoking by:

- providing training, skills and resources to support young people to remain smokefree and vape free.
- delivering smokefree campaigns that are co-designed by young people.

Alignment with Health and Wellbeing Board and Integrated Care Strategies

Key priorities for improvement

We align with the ambition to narrow the gap between those with the best and worst health and wellbeing and to reduce preventable ill-health.

- Starting Well focus on reducing the number of women smoking in pregnancy
- Living Well priority to accelerate reductions in people smoking focusing on more deprived communities.

Clustering of key lifestyle risk factors/behaviours

We align with the recognition of the key lifestyle risk factors,

- taking a holistic approach with various partners, regarding tackling unhealthy risk factors, to reduce health inequalities
- using local networks and partnerships to ensure our smokefree related activities and services are joined up to meet communities' needs.

Building blocks of health

We align with the recognition of the wider determinants of health, to realise a smokefree Hampshire by:

- taking a broader view on what makes people thrive, to ensure that the healthier choice is the easier choice.
- working with partners - trading standards, social care, housing and education, on cross cutting themes.

Hampshire Tobacco Control Alliance

Aims of the alliance

- develop an integrated and comprehensive programme, to reduce health inequalities by focusing action on the key groups most impacted by smoking in Hampshire.

- implement the tobacco control strategy via the **Hampshire Tobacco Control Action Plan**

- a stronger emphasis on place-based working to reduce smoking prevalence in Hampshire, including and working closely with partners across Hampshire communities.

Successes and current outputs

- Smokefree Hampshire 2030 campaign – to encourage more smokers to quit and signpost to help to quit when they are ready

- Expanded offer of support for smokers to quit and increasing publicity of offer.

- Hampshire Tobacco Control Alliance launch meeting on 9th February. Very well attended with good engagement to develop the tobacco control action plan.

Next steps

- Reinvigorate and embed the Hampshire Tobacco Control Alliance as key mechanism for delivering the Hampshire tobacco control strategy

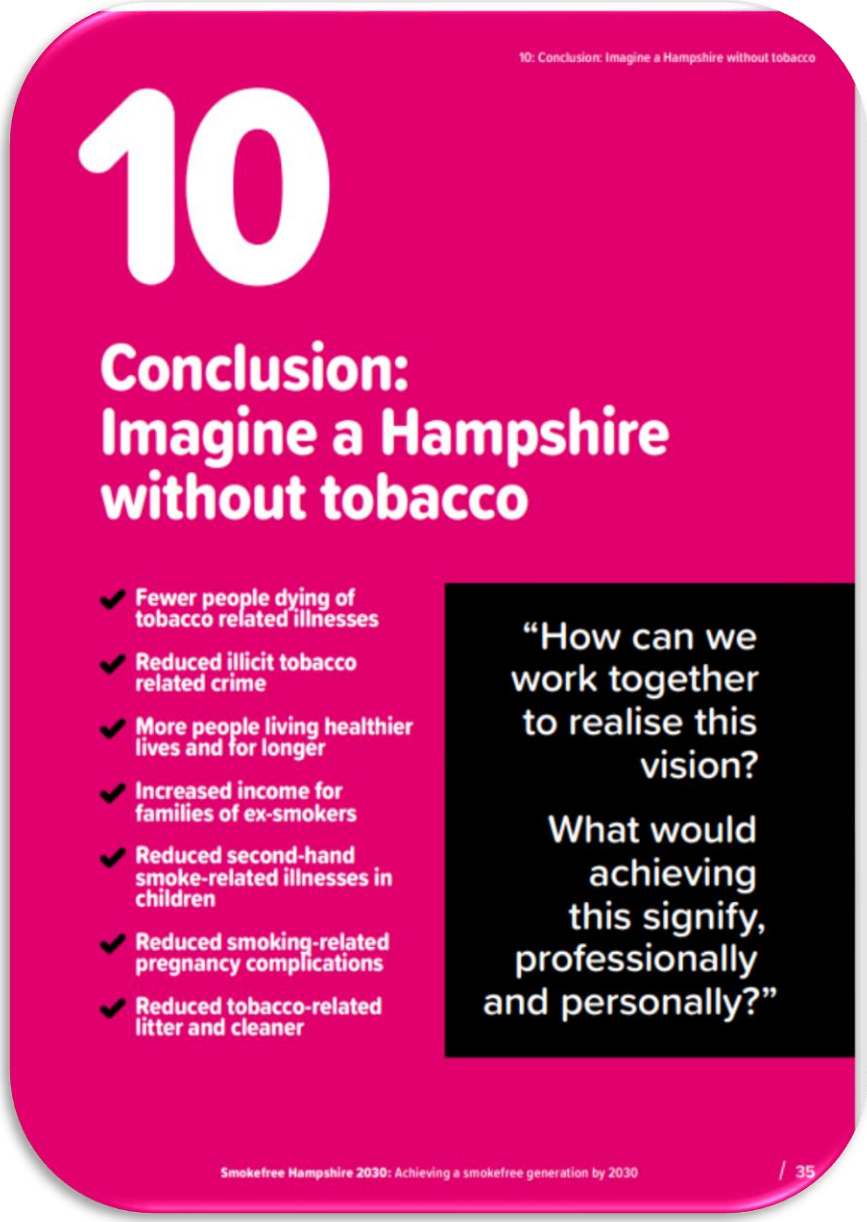
- Continue to encourage more smokers to quit, highlighting the free and expert led support available, Continue to promote Smokefree communities and reduce uptake in young people.

- Closely monitor and contribute to policy development around vaping in young people and develop and update our strategies accordingly

- Annual progress report to HIOW Health and Wellbeing Board

Simon Bryant
Director of Public Health,
Hampshire County Council

"With only seven years to secure a smokefree generation for Hampshire by 2030, the time to act is now"



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Health and Wellbeing Board
Forward Plan for Future Meetings
02 March 2023

Item	Notes	MAR 2022	JUN 2022	OCT 2022	DEC 2022	MAR 2023	JUN 2023	OCT 2023	DEC 2023
Strategic Leadership									
Health and Wellbeing Board Business Plan Update	Last received October 2021								
Board Survey Response and Actions	Last received July 2021								
Joint Strategic Needs Assessment (JSNA) Programme Update			X	X					
JSNA Work Programme and HIA Findings Summary	Workshops held on 29/11/21, 27/01/22								
DPH Annual Report: COVID 19 Inequalities in Mental Health and Wellbeing in Hampshire		X							
Health Protection Annual Report				X					
Hampshire Place Assembly and Integrated Care System Strategy					X				
Co-production	December HPA								
Terms of Reference Review					X				
Final Integrated Care System Strategy						X			

Item	Notes	MAR 2022	JUN 2022	OCT 2022	DEC 2022	MAR 2023	JUN 2023	OCT 2023	DEC 2023
Starting Well									
Joint Hampshire and Isle of Wight Children and Young People's Mental Health and Emotional Wellbeing Local Transformation Plan	Last Received December 2019								
Theme Focus	Last Received October 2020	X						X	
Household Support Fund and Cost of Living Resources					X				
Living Well									
Theme Focus	Last Received December 2020		X						X
Starting, Living and Ageing Well									
Hampshire Physical Activity Strategy	Last received October 2021								
Mental Health and Wellbeing Recovery Update	Last Received December 2020								
Hampshire Healthy Weight Strategy	Last received December 2021								
Suicide Prevention Strategy for Hampshire	Last received March 2018	X					X		
Healthier Communities									
District Forum Report on Housing and Health Topic	Last Received July 2020								
Theme Focus					X				

Item	Notes	MAR 2022	JUN 2022	OCT 2022	DEC 2022	MAR 2023	JUN 2023	OCT 2023	DEC 2023
Fire and Rescue Service Draft Community Strategy		X							
Aging Well									
Theme Focus						X			
Dying Well									
Theme Focus							X		
Integrated Care Systems									
The HIOW Integrated Care System (ICS) - National Context, Local Progress to Date and Next Steps	Last received March 2021								
The HIOW I Integrated Care System - Deep Dive	Last received July 2021								
ICS Update	Written Update November 2021		X						
Additional Business									
Forward Plan	Standing item	X	X	X	X	X	X	X	X
Integrated Intermediate Care (IIC)	Last received March 2021								
Modernising our Hospitals: Impact on Population Health in Relation to the Strategy	Last Received December 2020								
Election of Vice-Chairman					X				

Item	Notes	MAR 2022	JUN 2022	OCT 2022	DEC 2022	MAR 2023	JUN 2023	OCT 2023	DEC 2023
Pharmaceutical Needs Assessment			**X** (Draft)	**X**					
Hampshire Integration and Better Care Fund Plan 2021-22				**X** (Update)					
Annual Report									
Health and Wellbeing Board Annual Report	Summary shared for circulation		**X**				**X**		
Written Updates									
Autism Partnership Board Report	Circulated September 2020								
Hampshire Local Dementia Profile - Alzheimer's Society	Circulated September 2021								
Adults' Departmental Safeguarding Report	Circulated December 2021								
Annual Community Safety Strategy Group Report	Circulated December 2021								
District Forum Housing and Health Survey Findings	To be circulated								
Violence against Women and Girls Task Group Briefing	Circulated March 2022								
HIWFRS Community Safety Plan 2022-2025	Circulated April 2022								
Healthwatch Hampshire Annual Report 2021-2022	Circulated August 2022								
Hampshire Safeguarding Adult Board (HSAB) Annual Report 2021/22	Circulated October 2022								
Hampshire Safeguarding Children Board Annual Report 2021/22	To be circulated								

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