

Frimley Health and Care



The Living Well Ambition September 2022

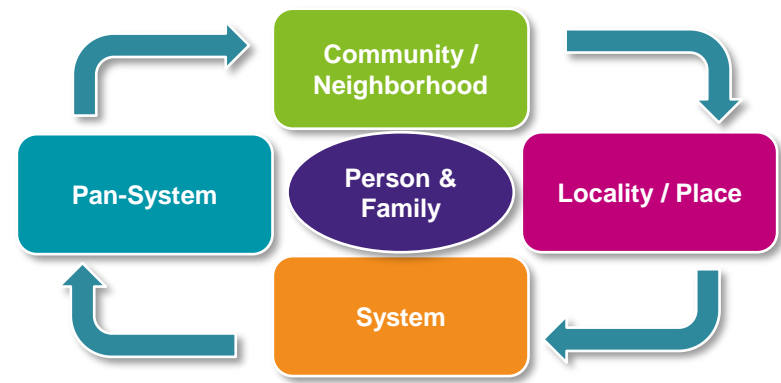


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Frimley Health & Care ICS: 5 Year Strategy - the story so far



Creating healthier communities with everyone

Delivering our strategic ambitions and overall objectives requires working at a variety of scales when planning, delivering and evaluating change.



The Living Well Ambition

- The Living Well Ambition is based on the premise that the long-term sustainability of our health and social care system depends on **people living longer in good health. Our people want to live and age well, able to live their lives to the full**
- Our aim is to **identify and target the cohorts of people** where physical and mental health outcomes can be improved, with a focus on deprivation, inequalities and those with most complex needs.
- The Living Well Ambition is **sponsored and delivered by teams working across organisations**, focusing on achieving improved outcomes for local people through better integration, transformation and innovation.
- We are **working collaboratively** across local authority, health, and voluntary sector **to understand and build our communities**, maximising the collective impact we can have on the health of our population.
- **Sustained focus on the stark intra-and inter place health inequalities** associated with poor, and worsening, health and wellbeing outcomes in our more deprived communities and other groups.
- Creating prevention programmes with our residents and local partners to create a **culture of prevention and self-care** collectively.



Principles Influencing The Living Well Approach

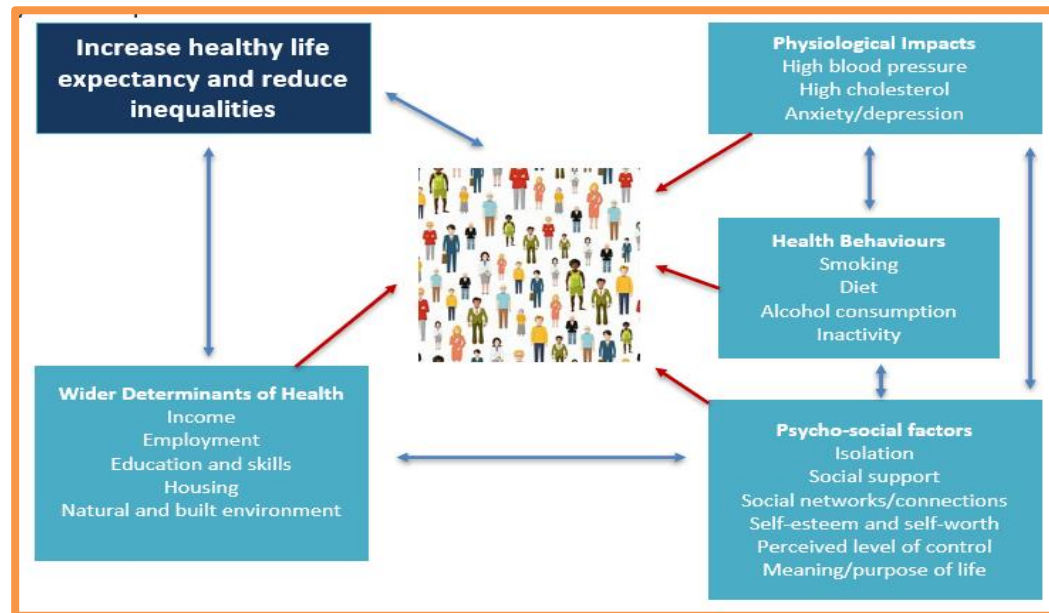
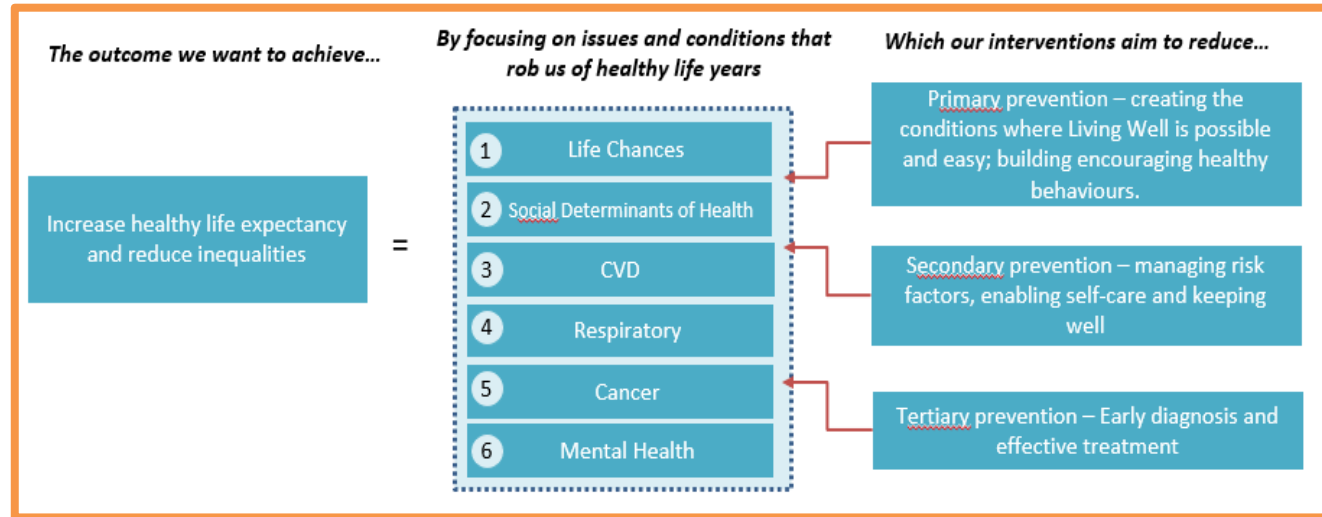
- The logic model
- Evidence based decision making using a PHM approach - clinical and demographic data
- Priorities based on community insights and co design with residents
- How we deliver is influenced by the ways of working across Frimley – partnership approach, health inequality focussed
- Networked across the system rather than silos
- Partners hold each other to account, rather performance managed



The Logic of Living Well

Our ICS goal is to increase healthy life expectancy at birth, by 2 years, and reduce the gap in healthy life expectancy between our least and most deprived communities, by 3 years.

We will do this through coordinated actions at system and place.





Collectively agreed 3 Living Well System Wide Priorities

CVD Prevention

- ICS CVD Prevention Group established.** Diverse range of colleagues coming together to develop a menu of opportunities.
- Oversee CVD prevention activities at Place,** unblocking and driving forward the delivery of the priorities in each of our Places. And **coordination, information sharing, support and collaboration across.**
- Hypertension has been identified as the primary focus for the next 12 months** (which threads into health checks and other modifiable risk factors), as there has been a sharp fall in treatment targets. Identifying and treating people with hypertension is a big priority for our system and where the greatest reductions in premature mortality can be made.
- A number of community approaches being explored** to build on the work that is currently underway.

Healthy Weight

ICS Healthy Weights Group established.

The aim is to enable Frimley ICS residents to maintain a healthy weight and to maximise their years of healthy life wherever they are and wherever they live in the ICS, while informing and empowering people to make healthy choices and delivering evidenced based programmes across the life course

Our aim is to:

- To increase the proportion of adults and children in the Frimley ICS who are of a healthy weight
- To reduce the proportion of adults and children in the ICS who are obese

Smoking

- Frimley Health Smokefree Steering Group established** to reduce the smoking prevalence across the ICS and implement the NHS LTP objectives relating to tobacco.
- driving the smokefree agenda across the ICS,
- provide and maintain oversight of the implementation of the Inpatient Tobacco Dependency programme that supports more people accessing secondary care to quit smoking.
- By 2024, 100% of inpatients and maternity patients across the ICS will be offered opt-out tobacco treatment services.
- Working collaboratively with LA/PH partners to improve linkages and coherence of the tobacco control and stop smoking offer across the ICS patch.



Other living well priorities

Areas Prioritised in the LW 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



Cardiovascular Disease Prevention

Frimley Health and Care



Living Well - Hypertension awareness and reduction

Overview of initiatives

- Campaign work, running specific campaigns and targeting engagement with groups at higher risk.
- ICS webpage for CVD prevention.
- NHS health checks.
- Digital Weight Management Programme.
- CORE20PLUS5 - hypertension case finding.
- Community hypertension bus pilot.
- Community pharmacy blood pressure (hypertension) service.



Know your numbers

Low BP	Top number Systolic Less than 90	Bottom number Diastolic Less than 60
Normal BP	90 - 120	60 - 80
High Normal BP	120 - 140	80 - 90
High BP	140 and above	90 and above

Learn more, visit www.frimleyhealthandcare.org.uk/bloodpressure

Did you know...

Find out more online at: frimleyhealthandcare.org.uk/bloodpressure
Blood pressure: Know your numbers

- AccruRx Florey.
- BP@Home.
- Health Checks at vaccination sites.
- Community hypertension pilot - devices in community
- Omron hypertension plus.
- Lakeside hypertension focussed days.
- 24-hour Ambulatory Blood Pressure monitoring and holter service.



Cardiovascular Disease Prevention

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Example approaches



A coordinated campaign with supporting resources

Bespoke resources created to provide information in printed, online and video format, with simple, straightforward messaging and advice. Tested with local people whilst in draft form. Designed to link with national and global hypertension awareness campaigns and provided in a comprehensive resource pack to staff and partners for use in their own communities.



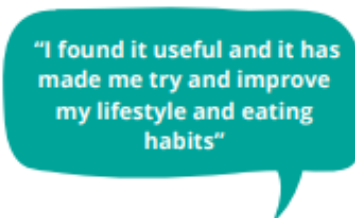
GP and clinician based interventions

GPs and local community pharmacies are identifying patients at risk of hypertension (but as yet undiagnosed) and offering a BP check or BP monitor for home readings. Health checks offered at the beginning of the year to those attending vaccination centres.



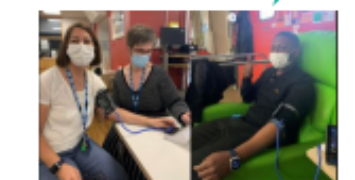
Community based monitors

Placing monitors in community venues where local people can more easily access them with the support of their community leaders and peers and in a safe, familiar and trusted environment.



Staff support and awareness

Staff encouraged to attend drop in sessions throughout May measurement month and get to know their numbers. Campaigns and resources highlighted throughout staff communications and in staff meetings.





Healthy Weights

Key achievements to date

- **NHS Digital Weight Management Programme**
- Frimley was an early adopter site for is now well embedded, **working in collaboration with LA**
- Our ICS is now the **highest performing system in the country** in terms of take up.
- The weight management services one pager and the ICS webpage being shared as an exemplar of good practice across the country.
- Updated overview to include **information on provision for people with learning disabilities** on the public website
- Digital offer that can be integrated or aligned with other local services.
- Referral form for DXS.
- This programme will also support our 'waiting well' programme.approx. 4000 people

Weight Management Services

- All 5 of our places now have a thriving Tier 2 Weight Management Service

Whole Systems Approach (WSA) to Obesity

- **ICS Whole Systems Approach (WSA) to Obesity workshop** delivered in conjunction with NHSEI and OHID colleagues, system partners incl voluntary and community sector. .
- **Surrey Heath's** successfully delivered 2 Obesity workshops, which was well attended.
- **Rushmoor's** WSA to Obesity Key Stakeholders engaged through a series of workshops.
- Community engagement has been highlighted as a priority and stakeholders are undertaking informal engagement activities within their settings.
- Rolling out Physical activity training in secondary care
- Active Medicine Programme – We are working with Get Berkshire Active (GBA) to explore the Active Practice idea.
- ICS Healthy Weights group established
- Healthy Behaviours HNA is underway delivered collaboratively by the three Local Authorities in East Berkshire. The aim of the HNA is to understand fully the health needs and not just what the data tells us but also to understand the community insights and what is important to the community



Smoking

Tobacco Dependence Treatment Services in the Acute

Tobacco Smoke Free Policy

Smoke Free Pledge

5 Community top Smoking Services

Health Improvement Campaigns

ICS Webpage

Aligning work to the CORE20PLUS5 approach





Investments we have made

- Community hypertension pilots
- Clinical Pharmacists
- Omron Hypertension Plus pilot
- Additional BP machines
- CVD Resources for our residents and staff
- Community Pharmacy Contract
- Healthy Weights Project resource
- Inpatient Tobacco Dependency Service

Measuring the Impact of the ambition

- Avoided admissions - cost avoidance and productivity gains
- Allowing services to deliver care for increased numbers of patients, whilst increasing quality, self-care and compliance.
- Indicators and outcome measures (PHOF, Shared Care Record, QOF).
- Working with PHE
- Evaluate the engagement work

Benefits already being seen

- **Closer collaboration and partnership working with Health, local government and the Voluntary, Community and Faith Sector at place**
- **People are engaged and have the skills**, confidence and support to take responsibility for their own health and wellbeing
- **Improvement in health literacy and outcomes** resulting in better prevention and self-management e.g. via Social Prescribing
- Our **most vulnerable cohorts and populations have improved physical and mental health outcomes**
- Strengthening communities through **recognising, identifying and harnessing existing 'assets'**

Collaboration learning across the system

- Aligned delivery with the other Ambitions
- Improve communication and working relationships
- Provide a better experience for our residents
- Strengthening relationships with places and wider stakeholders
- Support places to develop comparable outcome measures
- Share evidence of best practice
- Peer support, networking and influencing
- Evidence base and prioritised set of priorities



The key priorities for 2022-23

1. Continue with our 3 main priority areas (CVD Prevention, Healthy Weights, Smoking)
2. Focus on Health Inequalities - to improve and reduce variation in health outcomes across disease areas in our system
3. The Living Well ambition to be delivered at 'place' but within a system framework - 9 Priority areas
4. Support Health Improvement behaviour change programmes across the ICS
5. **CVD Prevention** - Focus on prevention and management of **Hypertension** – brief interventions for smoking and alcohol, links with community deal, better management of hypertension
6. Support **community engagement** with groups with poorer health & wellbeing outcomes to understand barriers and develop solutions
7. Roll out **Tobacco Dependency programme**, to ensure the provision of a resilient, sustainable programme that supports more people accessing secondary care to quit smoking.
8. Renewed commitment to **smoke free sites** (sign smoke free pledge) across our services and develop a tobacco control and e-cigarette strategy
9. Scope and start to develop Frimley ICS **Healthy Weights Strategy** and action plan (consider system-wide approach learnings from Amsterdam and the outcomes of the Health Needs Assessment).
10. Contributing and aligning to the **CORE20PLUS5** approach
11. Build on the Health promotion campaign work
12. Explore **staff offers of support** around: Smoking, Healthy Weight and hypertension, including rolling out staff NHS Health Checks in the Trust – Workplace Health
13. Enhance Physical Activity awareness in secondary care – moving towards activity prescription in clinical practice and training for staff
14. Social Prescribing response – continue to use the Social Prescribing function to support vulnerable people, linking with community hubs, long waiting lists
15. Healthy Conversations e.g. MECC – opportunistically encouraging individuals to consider their lifestyle and health with a view to identifying small but important changes.

Thank you

**IN THE END, IT'S
NOT THE YEARS IN
YOUR LIFE THAT
COUNT. IT'S THE
LIFE IN YOUR YEARS**

