Frimley Health and Care

Frimley ICS - NHS Joint Forward Plan

2023/24 – 2027/28

This Joint Forward Plan has been approved by the Boards of:

- Surrey and Borders Partnership NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- NHS Frimley Integrated Care Board

In June 2023

Frimley Health and Care

Introduction

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About this Document and Relationship to Other System Strategies and Plans

Our recently published ICS Strategy - Creating Healthier Communities - provides the overarching vision for how the Integrated Care System will work together to improve health and wellbeing across the Frimley geography. It sets out the key priorities and ambitions for the next decade and provides a framework for decision-making across the partnership.

This Joint Forward Plan is fully aligned with the ICS Strategy and it outlines how the local NHS will contribute to achieving our shared goals and priorities. In particular, the Joint Forward Plan describes how the NHS will work in partnership together to meet our headline strategic objectives of reducing health inequalities and increasing healthy life expectancy.

The Frimley ICS 2023/24 Operational Plan sets out the detailed plans for how the partnership will achieve its priorities in the first year of implementation. It includes specific actions, targets and milestones for each of the priority areas identified in the Planning Guidance released in December 2022. It represents many of the year one actions of the Joint Forward Plan, although it should be noted that the latter is more ambitious and expansive than the national minimum planning requirements for the year ahead. The Joint Forward Plan also provides a longer-term perspective on how the NHS will evolve its services and workforce over the next five years, to support the achievement of the ICS priorities in the longer term.

Overall, the Joint Forward Plan is an essential document for the implementation of both the longer term ICS Strategy and the year ahead requirements of the 2023/24 Operational Plan. It maps out the NHS contribution to the partnership's goals and provides a clear framework for decision-making and resource allocation over the next five years. By aligning with the ICS Strategy and the Frimley ICS 2023/24 Operational Plan, the Joint Forward Plan ensures that the NHS is working in a coordinated and integrated way with other organisations across the partnership. This document, refreshed on an annual basis, will help to maximise the impact of our collective efforts to improve health and wellbeing across the geography.

In summary, this Joint Forward Plan is an important document that provides a clear roadmap for the evolution of NHS services and its workforce over the next five years. By working in partnership with other organisations across the Integrated Care System, we can ensure that we are delivering the best possible outcomes for patients, while making the most efficient use of our resources.

Introduction from Our Organisations to this Joint Forward Plan

As the Chief Executives of the NHS in Frimley, we are pleased to present the NHS Joint Forward plan, which outlines our shared vision for the future of healthcare in our geography. We have worked closely as partners to develop this plan, which is rooted in the principles of collaboration, partnership working, improving patient outcomes, and reducing health inequalities.

Our region is diverse, and the healthcare needs of our communities are complex. We recognise that no single organisation can meet these needs alone. That is why we are committed to working together, across organisational boundaries, to improve the health and wellbeing of everyone in our region. We believe that by working in partnership, we can deliver better outcomes for our patients, enhance the quality of care we provide, and ensure that healthcare services are accessible to everyone who needs them.

Our Joint Forward Plan has three overarching objectives: to improve the health and wellbeing of our communities, to provide high-quality care to all our patients, and to ensure that our healthcare services are sustainable for the long term. To achieve these objectives, we have set out a range of ambitious goals, including:

- Increasing our focus on reducing health inequalities and increasing healthy life expectancy, as our contribution to the achievement of the ICS strategic objectives
- Developing our clinical services in a way that ensures they are fit for the decade ahead, delivering improved patient outcomes and experience
- Supporting our workforce and growing the capacity of those who work in delivering our services to address what is our greatest strategic challenge
- Making the best use of our shared resources to ensure that we can meet the needs of our population on a long term, financially sustainable, basis

We recognise that achieving these goals will not be easy. It will require significant expertise, collaboration, and a willingness to directly confront problems which have proved difficult to solve over a numbers. We are committed to making this happen though, and we believe that by working together, we can deliver a locally reformed healthcare system that is fit for the 21st century.

We are particularly proud of our focus on reducing health inequalities. We know that some groups in our region face significant barriers to accessing healthcare services, and we are determined to break down these barriers. We will work in partnership with local communities to understand their needs and priorities, and we will tailor our services to ensure that they are accessible, culturally sensitive, and responsive to the needs of everyone in our region.

We believe that our Joint Forward Plan is a blueprint for the future of healthcare in our region. It is a plan that is grounded in the principles of collaboration, partnership working, improving patient outcomes, and reducing health inequalities. It is a plan that reflects our commitment to providing high-quality care to all our patients, and to ensuring that our healthcare services are sustainable for the long term.

We hope that you will join us in our mission to transform healthcare for our population. Together, we can build a healthier, happier future for everyone who lives here.

Graham Wareham
Chief Executive
Surrey and Borders Partnership
NHS Foundation Trust

Julian Emms
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Berkshire Healthcare
NHS Foundation Trust

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Dr Huw Thomas and
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Board Partner Members

Fiona Edwards
Chief Executive
NHS Frimley
Integrated Care Board

Creating Healthier Communities – Our 2023 ICS Strategy

The Frimley ICS Strategy

Creating Healthier Communities was published in 2019 as the first Frimley Health and Care ICS Strategy. This was designed following significant co-production between partner organisations, the third sector, our workforce, patients, and the public. The ICS 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 delivery between 2019 and 2022. We have recently completed a new partnership-led refresh of the ICS Strategy which sets out our aspiration for long term improvement to the health and care of the population.

Our Integrated Care Partnership

The Frimley Integrated Care Partnership (ICP), established in July 2022, is a joint committee between 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, the Frimley ICP was established 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 population's 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 ICP is not an NHS construct and is, therefore, out of scope for this Joint Forward Plan. It will, however, continue to develop and evolve under the direction of a cross system partnership comprised of NHS, Local Government and VCSE expertise.

Frimley Health and Care

Our Population

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About the Frimley Health and Care System

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, inclusive of 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 first partnership plan was published, which set out our aspiration to unlock the benefits of greater partnership working and to 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 architecture which regularly changes around us.

The co-owners of this Joint Forward Plan are NHS Frimley, the local Integrated Care Board, and the three NHS Provider Trusts which provide services to our population in this geography:

- Surrey and Borders Partnership NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Frimley Health NHS Foundation Trust

Together, these organisations are responsible for the allocation and spending of over £1bn of the daily healthcare needs of our population.

Frimley Population Insights: Deprivation, Ethnicity and Disease Prevalence

There is a strong association between certain health conditions such as diabetes, chronic obstructive pulmonary disease (COPD), and heart failure, among others, with deprivation. We also see lower prevalence rates for cancer and atrial fibrillation in deprived areas, which could reflect under-diagnosis.

On average, 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

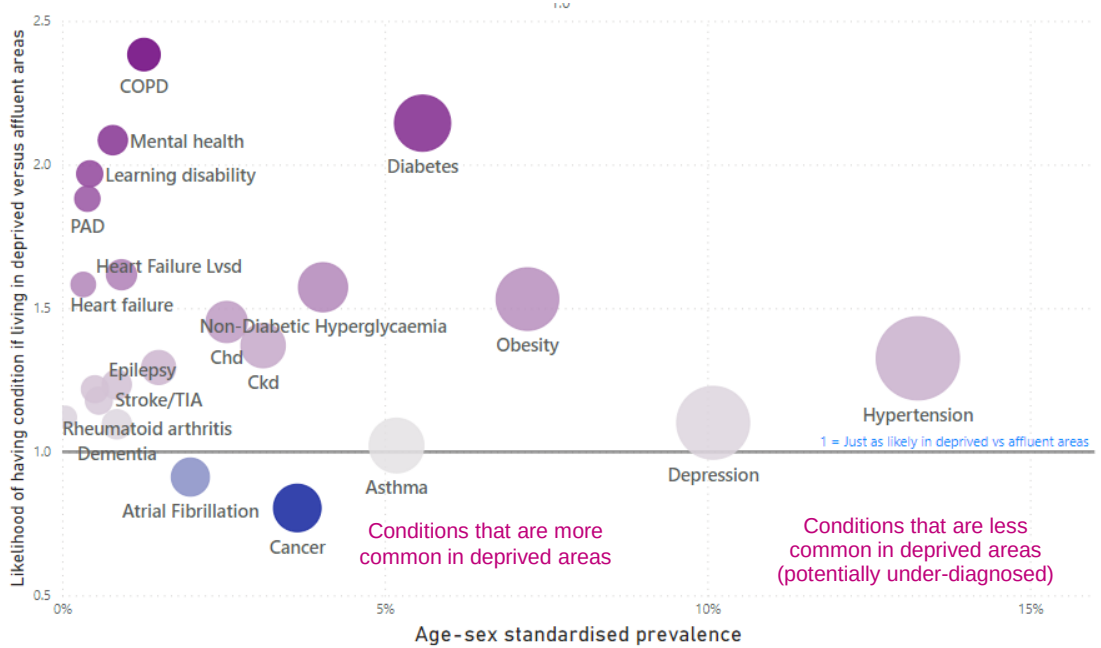
When looking at ethnicity data we notice the following:

- Asian / Asian British populations have notably higher rates of diabetes, non-diabetic hyperglycemia and coronary heart disease (CHD), and lower rates of depression, COPD and atrial fibrillation
- Black / Black British populations have notably higher rates of diabetes, hypertension, chronic kidney disease (CKD) and obesity, and lower rates of depression, COPD, and atrial fibrillation

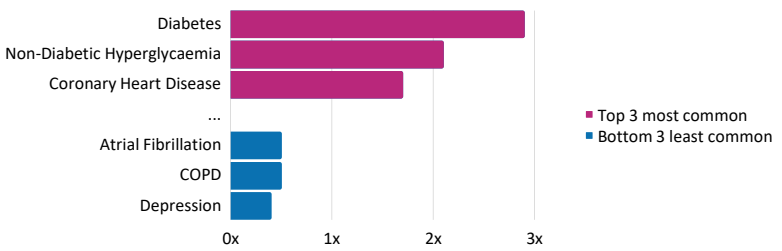
Slough, compared to other parts of the system, has a younger population, a higher percentage of BAME residents, more densely populated and multigenerational households, and is more deprived.

Adjusting for age and sex, Slough has a 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.

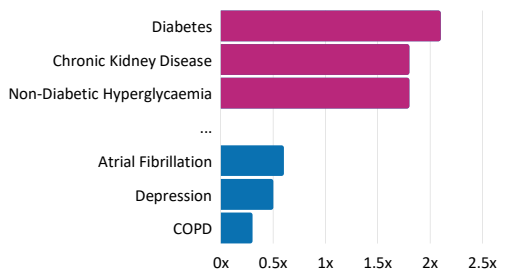
An increased prevalence of chronic diseases can lead to health inequalities, as well as increasing the risk of experiencing a disproportionate negative impact from community transmitted conditions, such as Covid-19.



Asian or Asian British compared to White population



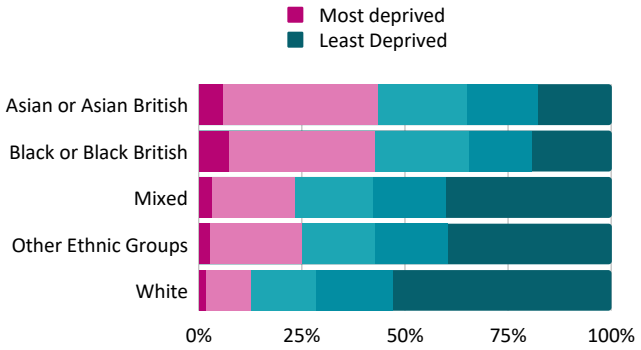
Black or Black British compared to White population



Frimley Population Insights: Wider Determinants of Health

CONNECTED CARE

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

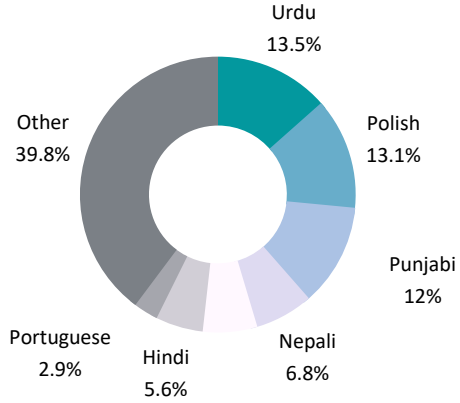


33.1% of BAME residents live in deprivation deciles 1-4, compared to 12.6% for White residents. Some key communities with known health inequalities are much more likely to live in deprived areas. For example, the Gypsy Roma Traveller community are almost seven times more likely to live in the most deprived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

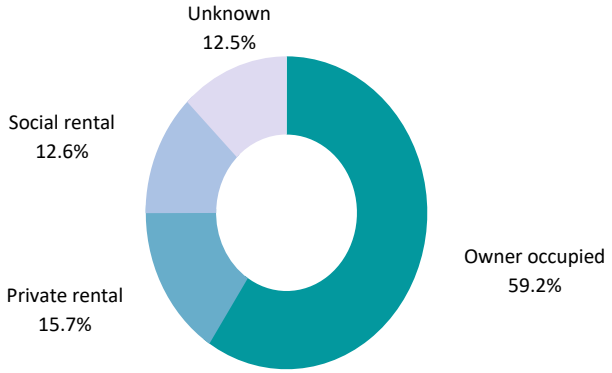
There are 122 different spoken languages in our population

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 person's ability to access and navigate health and care services



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



10.6% of the population are smokers

5.8% of the population have a BMI over 35

7.5% medium to high alcohol consumption

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

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 consumptions and are less likely to smoke (or have COPD). Smoking and alcohol rates are based on what is reported in GP records.

Frimley Health and Care

NHS Surrey and Borders Partnership NHS Foundation Trust
NHS Berkshire Healthcare NHS Foundation Trust
NHS Frimley Health NHS Foundation Trust
NHS Frimley Integrated Care Board

Frimley Health and Care

Service Transformation Priorities for our Population

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Our Clinical Services – Strategic Focus Areas for the Next Five Years

Introduction

As we move forward, it is essential that our services are equipped to meet the ever-evolving needs of our population. In this chapter of the Joint Forward Plan, we set out a roadmap for how we will develop and adapt our services to best serve the people who live in this geography.

Looking to 2023/24 and the four years beyond we examine a range of services from healthcare to social support, and identify what needs to happen to ensure that they are fit for purpose. We recognize that a one-size-fits-all approach is not sufficient when it comes to meeting the diverse needs of our population, and, therefore, we will take a tailored approach to service development.

To support reducing the disparity in healthy life expectancies and optimise how services are used, we will encourage the integration of services across acute and rehabilitation, and physical and mental health needs.

The key success factors, risks, and dependencies of our service development strategy are explored in this section. We understand that the success of our plan depends on a range of internal and external factors, from securing funding and building partnerships to ensuring that we have the right staff with the right skills in place. We will work collaboratively with stakeholders, including the public, to ensure that we are meeting their needs in a way that is both effective and efficient.

We recognize that there will be challenges and risks associated with service development, particularly in the wake of the Covid-19 pandemic and the recovery of services. However, we are committed to taking a proactive and adaptive approach to ensure that we are able to navigate these challenges successfully.

Ultimately, our goal is to ensure that our services are accessible, inclusive, person-centred and responsive to the needs of our population. By taking a comprehensive and strategic approach to service development, we are confident that we can achieve this goal and make a positive impact on the lives of those who live in our geography. Using this Joint Forward Plan as a base, the Frimley Clinical Reference Group will steward the production of a fully refreshed Clinical Strategy during the Summer of 2023.

Core20 PLUS 5

We are committed to implementing the Core20PLUS5 methodology to help us achieve our primary objective of reducing health inequalities. We will continue to work with our clinical and professional leaders at Place to identify PLUS groups who would benefit from additional focus on improving health outcomes, as well as accelerating our work to improve the healthcare offer for those in deprivation deciles one and two (the most deprived 20% of the population) and, where appropriate, those in deciles three and four. Further information about this methodology is set out on the following page.

Core20 PLUS 5 – Harnessing the National Methodology for Local Improvement

Background

Core20PLUS5 is a national approach developed by the Health Inequalities Improvement Team to support Integrated Care Systems to reduce health inequalities. There is strong strategic alignment between this approach and the Frimley ICS Strategic Objective of reducing health inequalities.

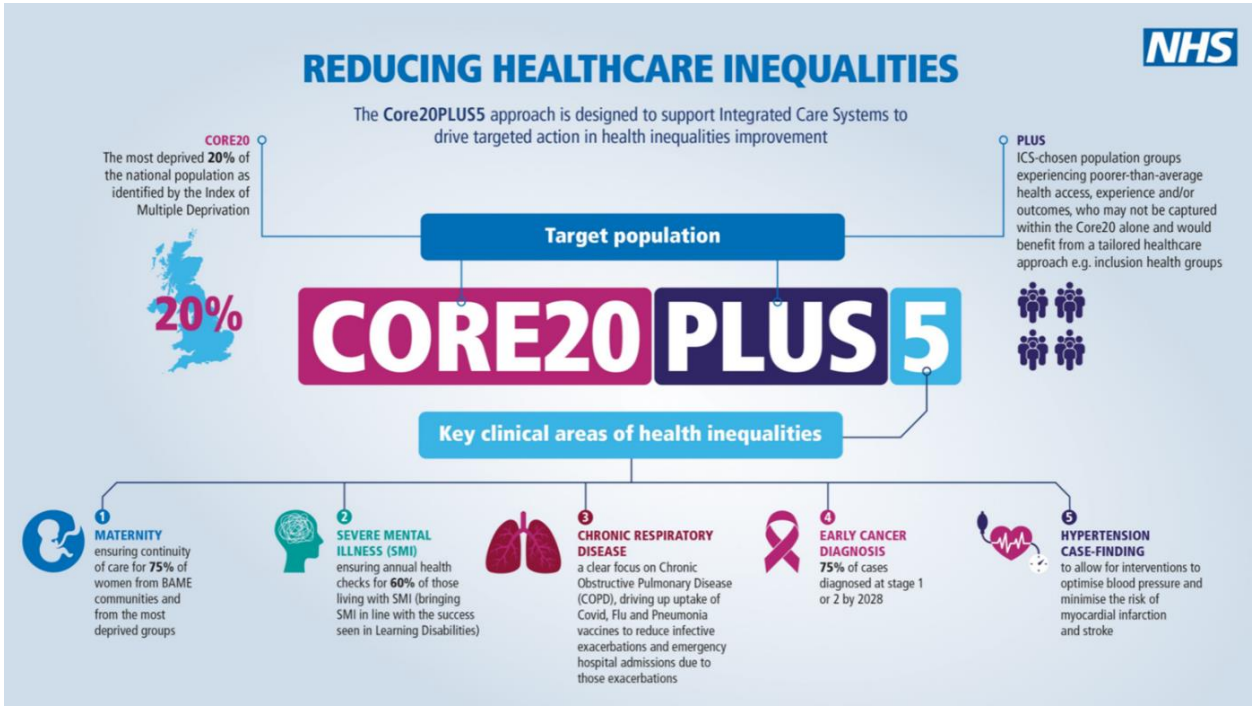
The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement. The Core20 target population is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

Navigating this document using the Core 20 PLUS 5 approach

Our service transformation priorities have been designed with this approach in mind. Each and every one of the ten service areas highlighted in the chapters which follow have been examined to ensure alignment with our ICS Strategy, which seeks to reduce health inequalities and increase healthy life expectancy for our entire population.

Some of our ten identified service areas have a distinct and additional alignment to the Core20 PLUS 5 national methodology. Where this is the case, these are easily identified by the adjacent graphic which has been added to subsequent page headers where appropriate.

Clinical and Professional leaders are continuing to work to identify the PLUS groups which would benefit most from a further tailored approach to meet their needs within each of our five Places. Further information will be made available and shared with residents and staff when this work has been completed.



Using a data driven approach to reducing health inequalities

The Frimley system has extremely accurate and granular information which helps us identify those who are either in the bottom 20% of IMD cohorts, the next 20% (where appropriate) or in a PLUS group. Over the pages that follow, you will find information which further describes our aspiration against the five high priority clinical areas of focus.

1. Children and Young People – Strategic Context

Introduction

The development of this new ICS Children and Young People (CYP) portfolio transformation plan marks a 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. This includes the health of children in care and care leavers.
- The pandemic has widened existing health inequalities and worsened the health of our CYP, particularly their mental health
- The cost-of-living crisis will affect low-income households more, predicted to bring half a million for children into absolute poverty this year, and this is set to worsen in coming years
- 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 players and stakeholders who will be instrumental in delivering it. They are committed to ensuring this plan succeeds and transforms the lives of CYP across Frimley. The ICS has invested in a small team of experts to help lead its delivery, in partnership with our 5 Places and providers.

1. Children and Young People – Key Challenges

202,000 people aged 0-19, 24% of the total population.

Over 8,000 live births a year. Slough has the highest fertility rate in England.

26% are black minority ethnic background (BME). Ethnic diversity varies greatly (13% in Bracknell Forest; 60% in Slough)

Slough also has a high rate of children who do not have English as a first language (55% in 1° school, 46% in 2°).

Approximately 15% of pupils have a special educational need.

Approximately 750 looked after children. Slough and Bracknell Forest have high rates of child protection plans

Significant variation in the proportion of 2 to 2.5 years receiving a development check – and in the proportion who meet the expected level in the 5 skill areas.

We have an association between excess weight and deprivation, which is more evident in the older age group (year 6).

1,500 of those aged 0-19 are known to smoke.

Sexual health

Proportion of 15-24 year olds screened for chlamydia and the case detection rate is worse than the England average.

Modelling suggests there could be 26,000 children living in households with domestic violence and abuse, parental substance misuse or parental mental health.

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

There are concerns that the cost-of-living crisis will mean that half a million more children will be living in absolute poverty in 2022 in the UK, and this trend will continue through to 2027.

More than 8,000 (8.5%) children aged under 10 in Frimley are currently living in deprivation and in poorly insulated homes.

1. Children and Young People – Our Five Year Priorities

	Current state	Vision
Improving SEND	Services are not widely or consistently accessed at the earliest opportunity, only when concerns around SEND hit a certain threshold. An overemphasis and misconception in the need for a diagnosis before receiving support and advice, with education and health working in silos. Those working with, caring for and supporting children with SEND are not aware of the wide variety of information and strategies available.	All children and young people with SEND tell us that they can access the right support, the right service, at the right time. We have removed and overcome the barriers and labels that prevent this. All-inclusive services focused on early support and intervention, with strong partnerships between education and health Everyone working to support them are confident to contribute to and lead discussions focused on individual needs (not diagnosis) and goals that achieve everything they aspire to be.
Children with life-long health needs	Demand in specialist services outstrips capacity within the health service leading to excessive case loads, which can lead to children waiting for longer to access health professionals for support. Often children will end up in ED or admitted to hospital, where opportunities to avoid this have not been possible due to a lack of community provision. Children with life limiting conditions are often not able to die in their place of choice because of the current service landscape.	Children easily access a wide range of local support to help them manage their life-long health needs, improving their health outcomes and confidence. Young people experience a positive transition to adult services with no negative impact on their health and care needs.
Transforming CYP Mental Health	Services to children and young people can be inconsistent, over medicalised, and difficult to access. Children and young people, families, and professionals, are having to navigate this complexity. There are layers of inequity and disempowerment, often resulting in a reactive 'risk' response to mental health and wellbeing.	A streamlined system with no wrong door, where children and young people, families and professionals can access the right support at the right time in a seamless way. There are reduced inequalities and greater empowerment, with an emphasis on early help from a holistic system approach that treats the person not the condition. A proactive approach which puts the child's wellbeing at the very centre, and where they are experts in their own care.
Starting Well	We know that some infants and children are getting a better start in life than others, with outcome data such as vaccinations, mortality, and childhood obesity indicating that some do much better than others. Much of the variation in how well children's lives start is caused by deprivation. The cost-of-living crisis has further challenged many families and will impact on their children.	A health offer that will ensure health outcomes are consistent for all children and young people. The use of data and insights to proactively target and support those children and families where there is a disparity in health outcomes because of wider determinants. Children are 25% of our population now but 100% of our adult population for the future, so we will be investing now to create healthier communities where future generations will rely less on NHS services.
Transforming Neurodiversity Services	Children and young people with neurodiversity face multiple inequalities, are at greater risk of coming into Local Authority care or lengthy mental health inpatient care, and experience assessment, support, and help that is slow, fragmented and hard to navigate.	A place where: • The strengths of people who are neurodiverse are nurtured and celebrated • The needs of neurodiverse people are met without the need for diagnosis, wherever appropriate • Care is joined up so that families can find and access help and advice services from a range of partners swiftly and easily • Neurodiverse children are less disadvantaged in terms of home, school, health and wellbeing, compared to their peers

1. Children and Young People – Our Priorities for 2023/24

Actions	How they will be delivered	By when	Risks to not delivering
Children's mental health Fund and implement the psychiatric liaison team at Frimley Park Hospital	• Review of baseline budget has enabled this to be funded from within the existing baseline provision for the coming year. In the years ahead we will seek to move this with the NEHF CAMHS provision to the standard contract with SABP (aligned with CYP MH Transformation Programme)	April 2023	Responsible Clinician requirements will not be met, carrying significant risk in relation to the Mental Health Act. CYP are at risk of remaining in acute settings for unnecessary lengths of time leading to reduced flow through paediatric wards
Children who are waiting for a surgical intervention	• Work with FHFT to understand the recovery rate, how it compares to adult recovery and regional recovery. Work towards replicating Children's surgical days that concentrate resource for a day into high volume paediatric lists, capitalising on summer months within children's services		
Children with life-long conditions Scope provision of a psychology support service for young people with long term conditions, to reduce escalating mental health need within these services, and to address clinical psychology workforce gaps.	• Utilise vacant post at FHFT alongside additional investment to fund VCSE organisation to deliver tree of life workshops to all children with life-long health needs (aligned with CYP life-long health needs)	Sept 2023	Escalation of complex mental health need into CAMHS
Children with learning disabilities Address gap in provision for children with a learning disability in East Berkshire	• Implementation of CAMHS provision for young people with a learning disability in East Berkshire. • Service development hosted by LDA team with cross-support from the children's team (aligned with both CYP MH and LDA Transformation Programmes)	April 2023	Spot Purchasing spend around this cohort of CYP will escalate. Needs are unmet leading to crisis and risk of admission to acute settings and high-cost residential placements
Children in care and at the edge of care Reduce health inequalities faced by children in care	• Implement a trauma informed children in care CAMHS provision focussed on early intervention and attachment disorders (aligned with CYP MH Transformation Programme with a particular focus on Transitions) • Establish a clear process whereby care leavers do not have to make a choice between paying for a prescription or rent, purchasing prescription certificates for young care leavers until aged 25. Anticipated cost up to £40,000 per year	Sept 2023	Evidence demonstrates that care leavers are at higher risk of entering adult service provisions, particularly mental health services. Specialist support at point of leaving care will reduce this risk
Children with mental health needs – eating disorders Improve monitoring of children and young people with an eating disorder	• Supporting BHFT to re-purpose existing funding to recruit to a GP with special interest role (GPSI) embedded within the ED team	April 23	Fragmented continuity of care which could destabilise recovery and long-term outcomes
Children with asthma Deliver asthma transformation plan	• Recruit clinical project lead nurse to drive cross organisational improvement. Continue to report to regional team on progress (aligned with CYP life-long health needs)	April 23	Reduced support to CYP with long term conditions
Amplifying the voice of children and young people Fully establish the Youth Board, which should include care leavers	• Appoint a youth voice worker to embed the youth board into our work, ensuring meaningful engagement with our young population and linking with existing groups to ensure everyone is heard fairly in the work that we do • Targeted recruitment to care leaver population	April 23	Reduced compliance with key enabler around Engaging the CYP voice
Children who are neurodiverse Improve wait times for Autism/ADHD assessments	• Maintain additional investment to support access to assessments (aligned with neurodiversity transformation programme)	April 23-March 24	CYP will continue to experience inequity of provision and long wait times
Children with Special Educational Needs and Disabilities Integrated therapies	• Maintain additional investment to support remodelling of service to deliver timely service to CYP with complex needs (aligned with SEND Transformation Programme)	April 23	CYP will continue to experience inequity of provision and long wait times
Proactive/early intervention and self-management Expand use of Healthier Together app to try to divert low need/low risk children from urgent emergency care services	• Maintain current development and maintenance of key digital enabler	Ongoing	Reduced community support for range of CYP health issues
Children with complex needs housing and support options Supporting local residential provision for complex care children	• Provide input to project group around capital programme (capital bid for 22-23 successful)	23-24	Closer to home provision for hard to place complex care CYP will prevent CYP going into crisis and reduce the likelihood of becoming a child in care
Children with continuing health care needs Establish dynamic purchasing framework for continuing care agency packages	• Supporting children's continuing care to develop a dynamic purchasing framework to improve quality and reduce costs associated with short notice agency provision. • Establish system escalation route between system and place to identify young people for whom earlier intervention will prevent escalation to more restrictive care arrangements, including out of area placements and safeguarding risks. Engage an external review of the packages of care currently in place, working with commissioning teams in LAs to provide assurance around quality of care provided by agencies. • Agree joint commissioning approach for supporting children with complex mental health and behavioural needs, working across CCC, LDA and CYP portfolios to enable a 'think family' approach.	23-24	Continuing high-cost placements and budgetary pressures
Partnerships and working together with children and young people	• Host a CYP conference to highlight the health inequalities that children face and explore further opportunities for partnership working and further develop the voice of CYP across Frimley.	23-24	
CYP ARRS Roles	• Promotion of specialist CYP MH roles within primary care	23-24	
Review of MHSTs	• Consideration of effectiveness of current partial coverage as a whole school approach and exploration of other approaches to increase coverage e.g., MyHappyMind	23-24	

1. Children and Young People – Dependencies, Enablers, and Risks to Delivery

Strategic enabler	Our ambition
Bringing the authentic CYP voice	CYP voices will be heard at the highest level across our ICS and will be central to everything we do. We are 'going for gold' on how we ensure CYP co-produce, co-create, champion and drive our transformation programmes. Our assurance on the progress we are making will come from CYP. We are working to establish a youth board to support the work that we do and to hold us to account on the progress we make.
Having 3rd sector and housing partners at the heart of our portfolio	We will build a robust coalition of CYP third sector, housing, community and 'for profit' providers. This will bring together the skills, expertise, and strengths of the organisations working with, or for, CYP and unite them under shared and common goals. It will enable the ICS partners to connect and work with them in more meaningful ways.
Creating strategic partnerships with education	Schools are the organisations that understand children best, and we aim to develop more systematic ways of working and collaborating with them. Across our Places, schools are important anchor institutions, and we want to work with them to develop innovative ways to deliver primary and community care for our CYP.
Supporting new workforce models	Workforce challenges across our current CYP services are some of the greatest challenges described by our stakeholders. While the ICS People Programme works to support partners to improve recruitment and retention of CYP staff, we will also work to develop and test new workforce models. This will have an emphasis on supporting people with lived experience to build careers in CYP services.
Systematic use of data and insights	Understanding the need of CYP and where there are inequalities will continue to drive our priorities for transformation. It will help us understand the impact that our transformation programmes are having and provide evidence for where investment and further transformation should be made. The portfolio team includes a CYP lead from the insight team.
Collaborating with our neighbouring ICSs	Our neighbouring ICSs have supported our work to develop this new portfolio plan. We share an ambition to support seamless pathways across our boundaries and we understand the areas where we need to work together to improve this (particularly CYP mental health on the Frimley, Hampshire and Surrey border). We will continue to learn from each other, sharing successes and learning.

Risk	Mitigation
The impact of the cost-of-living crisis outstrips our work to tackle health inequalities.	We will continue to work closely with our place-based teams to ensure we are as proactive as we can be in responding to wider health determinants, using data and forecasts to inform any steps we take. We will be ambitious in our aims and will work closely with voluntary and community sector and other partners to deliver this work.
Workforce challenges risk the sustainability of current services and limits our ability to transform care.	We have built a team from multiple sectors, bringing their experience and understanding of current workforce challenges. We are working with the ICB workforce teams to explore our data and to build upon the wider educational reforms that enable alternative pathways to many careers. We are working with our partners to identify and enable alternative strategies to recruiting and retaining team members.
The complexity of different providers on ICS borders creates disjointed pathways	We have developed a shared understanding in the key pressing areas, such as children's mental health crisis provision and we are working together to meet our ambitions for seamless pathways. We are open about the challenges as they arise, and we work closely to resolve them.
We don't make the progress we want with transforming care because of the pressures within the system on the day-to-day management of children's services.	We are building the capability within our team to ensure that we can support services to deliver the day-to-day, whilst keeping a sharp focus on the strategic plans. We are establishing what our matrix working looks like to make best use of our skills and interests. We will continue to build on our relationships with all partners to deliver upon our shared ambitions.
The complexity of children's operational delivery networks, regional teams, local and tertiary providers increase the risk of duplication and emerging gaps.	We have ensured that we are represented in the developing boards and work groups to influence the formation of this work. We will continue to be considered in our approach and capitalise on national momentum for transformation we are undertaking.

2. Neurodiversity – Strategic Context

Our Vision

We have a vision that everyone across our system will recognise, understand, and celebrate neurodiversity. All neurodivergent people working in, or using our, services will be empowered and enabled to have equal access to effective services, to support and live fulfilling lives. Working together as a whole integrated system we are supporting each other to make Frimley a place where the strengths of neurodiverse people are celebrated and nurtured.

Our Pledge

We will co-produce with experts by experience

We will improve quality and access to services for neurodivergent people and their families

We will improve knowledge and awareness about neurodivergence

We will make Frimley a great place for neurodivergent people to work

Our Partnerships

Local Authority partners contribute significantly to the wellbeing of people with ADHD/Autism though their work in schools, the community and in supporting people to live well in the community.

2. Neurodiversity - Our Transformation Projects (1)

LDA Champion

Commissioned through Autism Berkshire and commenced role in November 2022. Role is focussed on:

- Championing reasonable adjustments across health services and for ICB employees who are autistic
- Promoting understanding and training in all key organisations
- Policy development

CAMHS LD Service in East Berkshire

- A joint service with Berkshire West, BHFT are developing our specialist service to support people who are autistic and/or who have a learning disability and require specialist CAMHS assessment/support.

Pre- and Post Diagnostic Service for Autistic Adults

Two-year project commissioned jointly with Berkshire West and Autism Berkshire to provide pre- and post- diagnostic information, advice, and group support service. Service commenced in November 2022 and is currently exceeding KPIs.

Autism Diagnostic Pathway for Adults

Project commissioned jointly with Berkshire West and BHFT to review the pre-autism assessment process for adults through:

- Reduced waiting times by making assessments more efficient and effective
- Increased use of digital technology
- Seeking and responding to feedback to improve the experience for people receiving assessment
- Streamlining admin process to focus clinical expertise on assessment and post diagnostic intervention rather than pre-assessment work

We need to work together to understand true demand. With the rate of referrals 238% of contracted levels, and assessments 172% of contracted levels (SABP), within the resources we have we must bring the costs back to a sustainable position.

2. Neurodiversity - Our Transformation Projects (2)

Keyworker Service

This is being developed as a response to the NHS England and NHS Improvement Long Term Plan (LTP) commitment that by 2023/24, children and young people with a learning disability, autism, or both, with the most complex needs will have a designated Key Worker. The Key working function is an important response to ensuring children and young people with a learning disability or autism who are at highest risk of admission, or are currently in inpatient mental health services, and their families, get the right support at the right time to prevent unnecessary admissions and to reduce length of stay to a minimum.

- The East Berkshire service will commence from 1st April 2023 and a provider for this co-produced service has been selected.
- The service for North East Hampshire is already in operation as part of the Hampshire-wide service.
- The service for Surrey Heath and Farnham is being implemented currently and is part of the Surrey-wide service.

PEACE Pathway (Pathway for Eating Disorders and Autism developed from Clinical Experience)

Peace aims to improve service provision and outcomes for people with both eating disorders and autism, through providing adapted care and treatment, and joined up care, recognising and removing common barriers to treatment and recovery and reducing treatment duration by getting it right sooner. This is a two-year project in conjunction with partners in the BOB ICS, utilising collaborative recruitment and shared resources.

Inpatient and Community Oversight

Our Dynamic Support Register is used to monitor our inpatients and also children, young people, and adults in the community who are at risk of admission, a number of whom are neurodiverse. We work closely with the Provider Collaborative and health and local authority colleagues to monitor inpatients, using processes such as Commissioner Oversight visits and Care and Treatment Reviews. We are developing stronger links with inpatient services to identify patients who may be neurodiverse but have not had a formal diagnosis.

2. Neurodiversity - Our Five Year Priorities

- Roll out the national programme of Oliver McGowan training
- Ensure that opportunities to bring neurodiversity to the development of the Provider Collaborative are explored and developed
- Further develop our support to children with Special Education Needs and Disabilities, bringing learning from the Portsmouth model
- Building an improved collaborative shared care model with primary care, with increased advice and guidance support
- Exploring partnerships with quality providers to reduce demand on services and deliver a tiered approach to rehabilitation; enabling a person-centred offer
- Building system understanding and ownership of the challenges faced by people with neurodiversity
- Develop our strategic partnerships with specialist housing associations and third sector providers to ensure children approaching transition have accommodation and support available to meet their needs
- Continue waiting list initiatives and the development of our shared ambitions to meet the needs of people without relying on an assessment
- Explore further the support needed for people from LGBT communities and additional support for transgender people
- Understand further the ‘Right to Chose’ process and how this connects (or not) to the waiting lists for assessments
- Continue to build capability and capacity of our workforce
- Cleansing waiting lists, minimising duplications with other providers, risk stratifying to inform model development, and appropriate care options, including maximising access to self management support
- Utilising software to automate pre-screening to increase flow and build workforce capacity

2. Neurodiversity – Our Logic Model Approach to Transformation

with these **INPUTS**	we carry out the following **ACTIVITIES**	creating the following **OUTPUTS**	to deliver the following **OUTCOMES**	with these long term **IMPACTS**
• Steering group of accountable officers from across health, education and social care offering system leadership • Recruit ND Transformation Lead • Baseline budgets and service offers around ASC /ADHD Assessment and support • Existing baseline CAHMS and other ND service providers , portage services, education settings and social care services • Established training programmes to improve understanding of both Neurodiversity and of trauma informed practice in the children's workforce • Children, young people and families who have ND, their voices and lived experience to inform future planning. • Residential placement, foster care and specialist placement provision for those ND CYP that need it.	• Extensive consultation and co-production with children, young people, families and other system partners to understand current barriers to long term objectives and options for addressing them that meet communities aspirations and needs. • Map existing capacity and spend against demand in the different parts of the ND offer • Further develop role of ND Network to shape provision • Identify successful models and make contact to learn from them • Review CAMHS specifications to improve accessibility and reasonable adjustments and identify costs • Articulate a plan for a ND "pathway/offer" model across the ICS with consistent referral/ advice criteria, test with CYP and families and implement • Roll out Oliver MacGowan (OM) statutory training to all health and social care staff	• Coproduced ND strategic plan in place including costed proposals for support services, assessment capacity and requirements to reduce waits for services • Publicly available clear and consistent care pathways for neurodiverse children around CYP mental health services • Improved patient experience and staff satisfaction • Waiting time from referral for assessment to first contact reduced • Number of staff who have completed Oliver MacGowan Training	• More ND CYP and parents / families report that support is better and meets their needs. • Improved inclusive and anticipatory practice in all settings • Coordinated and effective use of resources to support people who are neurodiverse to access information, support and to thrive in their families, communities and other home settings. • Fewer CYP experiencing breakdown of home life placement, admission to hospital or school exclusion. • When ND CYP do experience family, placement or education breakdown and/or need hospital admission, support is in place to reinforce family, service and community capacity to get CYP back into normal life. • Improved education, employment and home stability outcomes, and reduced inequalities for ND CYP	• Frimley is a place where the strengths of people who are neurodiverse are nurtured and celebrated. • The needs of neurodiverse children, young people and adults are met without the need for diagnosis, where appropriate • More joined up care so that families can find and access help and advice services from a range of partners swiftly and easily. • Neurodiverse CYP are less relatively disadvantaged in terms of home, school and/or health (including mental health breakdown) compared to their peers.

3. Mental Health Services – Strategic Context

The NHS Long Term Plan (LTP) built on the foundations of the Five Year Forward View, outlining a plan for further expansion and transformation of mental health services that would bring these services on par with physical health services and with dedicated investment, where previously this was limited. Delivering the LTP commitments has enabled us to improve the emotional wellbeing and mental health of Frimley residents and to create innovative partnerships. But the mental health needs of our population are increasing and there is still more we need to do.
We have used dedicated mental health investment which ends 24/25 to make more services available and improve access. We now need to maintain the focus on the transformation of mental health services in this new environment of increasing poor mental health in our communities, newly formed ICSs and a very difficult financial environment. In Frimley we have worked hard together to improve the experiences of people and their outcomes and ensure our services are efficient for both our patients and the health and care system.

We know from the latest data that:

- Common mental health condition rates in the population are significant (approximately 1 in 6 people aged 16 and over in England)
- In 2020 to 2021, there were around half a million people with more severe mental illness such as schizophrenia or bipolar disorder
- Children/ Young People's mental health is deteriorating - rates of probable mental health disorders in 6 to 16-year-olds has risen from 11.6% in 2017 to 17.4% in 2021. Our services (including CAMHS and Eating Disorders) are experiencing significant increased referrals and increased levels of acuity in our young people
- People in a mental health crisis and those sadly ending their life by suicide has increased over the past decade. We know that two-thirds of people who end their life by suicide are not in contact with NHS mental health services
- People who experience mental health problems are now 5 times more likely to die earlier compared to the general population and from avoidable causes. The gap is widening between people with and without an SMI dying before aged 75
- Mental illness is the largest cause of disability in the UK affecting 23% of our population

The impact of the pandemic together with the growing cost of living and financial pressures on the population is only likely to get worse, and it is now more than ever we need to focus on prioritising mental health support that is proactive, holistic, and equitable, leveraging existing resources at place and system that are fully integrated within local place neighbourhoods. Standing still is not an option.

In response to the increasing mental health need and acuity, we have established a Frimley Mental Health Provider Collaborative. The vision is to build emotionally healthy communities across Frimley and improve the lives of our residents living with poor mental health by using our collective expertise, resources, and creativity. We want to ensure high-quality care and treatment is easy to find when needed and that no one is turned away from a service without support to find the help they need. With future devolution of specialist commissioning this will in the future include Perinatal , learning disability forensic services.
This five-year plan for mental health aligns with the emerging ICP strategic ambitions and recognises that people living in Frimley's most deprived neighbourhoods are more likely to experience poor mental health than other residents, and that people living with a serious mental illness continue to experience a ***15-to-20-year life expectancy gap***. To address these inequalities, we need to:

- Move away from treating illness, and toward prevention and building the conditions for good health
- Support community engagement to co-produce solutions and reach communities where there are poorer outcomes to understand and address barriers to good health
- Promote the principles that everyone has a part to play in building and creating healthier communities, drawing on existing community assets
- Spreading population health management approach
- Strengthening relationships with the VCSE and our local places
- Recruiting people with lived experience to be part of the solution
- Supporting a healthy and fulfilled workforce and building their skills and capabilities

3. Mental Health Services – Key Challenges

Inequalities

Addressing health inequalities has been a priority in mental health for many years, as highlighted in the Five Year Forward View for Mental Health and the NHS LTP. With the COVID-19 pandemic, it has become more important than ever. The pandemic and its social and economic impacts are disproportionately impacting specific groups, including Black, Asian, and minority ethnic communities. We recognise there are inequalities in access, experience and outcomes as seen below:

- Our interviews with stakeholders highlighted that some groups had poorer experiences accessing or using services, including children and young people, people from minority ethnic groups, LGBT people, and people with more complex needs or more than one diagnosis
- Our most deprived neighbourhoods are more likely to experience poor mental health than other residents
- People living with a serious mental illness continue to experience a 15-to-20-year life expectancy gap, and the gap is increasing
- There are known health inequality outcomes and access to our services. Our data shows us that black individuals are less likely to access early intervention services and are significantly overrepresented in our crisis services. Our data also shows us that waiting times for CMHT varies significantly for different ethnic groups.
- There is a lack of appropriate and accessible services to support people with autism for example Talking Therapies#

Demand and Capacity

The need for mental health services has steadily increased over the years nationally however during the pandemic we have seen both a greater demand for and a need to support people with more complex and severity of illness, often requiring immediate inpatient admission or crisis support. This is demonstrated below:

- Lower numbers of people accessing NHS Talking Therapies (IAPT) but higher levels of complexity and acuity
- Demand and capacity challenges within community mental health services increasing and the need to continue to embed our Community MH Transformation Programme for people with SMI (including MHICs, secondary care transformation/One Team, SMI health checks, Individual Placement Support, Early Intervention in Psychosis)
- A lack of sustainable crisis alternatives to intervene early, prevent admission and keep people at home for longer including Home Treatment, Safe Havens, MH ambulance provision
- More complex patients with significant needs within our urgent and emergency (UEC) care services and high levels of demand with not enough capacity
- Inpatient beds at 98% occupancy with Frimley in the lowest quartile of bed base for MH which directly increases the number of people admitted to an out of area placement (OAP)
- Significant problems with flow in and out of our UEC services due to a high numbers and long waits and difficulties in discharging people who are who are clinically ready for discharge
- Workforce recruitment retention and wellbeing
- Lower levels of dementia diagnosis rates but lack of post-diagnostic support to avoid admission/accelerate appropriate discharge from hospital

Holistic Care (the whole person)

Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. Understanding the holistic needs of an individual is critical to supporting people into recovery and we recognise we cannot do this in the NHS alone. We see particular challenges in:

- Housing; to deal with multiple complexity there is not always the availability and/or suitable housing stock where people with MH needs are a priority for housing. Additionally, the availability and access to high quality providers is a challenge.
- Employment; we are seeing a decline in people being able to access employment opportunities. Meaningful engagement and employment is key to preventing mental ill health, keeping people well and supporting recovery.
- The equitable role of the Voluntary and Community Sector (VCS). Lack of funded, sustainable and networked VCS services to offer alternative psychosocial interventions to our population at an earlier stage is important in avoiding escalating needs. In Frimley inequitable levels of investment in the VCS and short-term contracts means we do not have a solid and equitable offer.

3. Mental Health Services – Our Five Year Priorities

Prevention and early intervention

- Invest in co-produced and evidence-based mental health primary prevention across Frimley's priority neighbourhoods to target inequalities e.g., skills sharing with communities, mental health literacy, anti-stigma and trauma informed campaigns, wholes school and parenting support
- All Frimley places to have a local suicide prevention action plan
- Roll out workforce wellbeing initiatives in partnership with Public Health and the Frimley business and enterprise sector to build more resilient communities and enhance economic growth within our geography
- Maximising the early intervention offer, making high quality, compassionate mental health support accessible and easy to navigate when people first need it including accelerating the uptake of Talking Therapies and front-loading support via strategic partnerships with the VCSE

Population health based and data driven

- Delivering evidence-based care pathways based on population data and clear demand and capacity modelling
- Extension of pathways from 0 – 25 (from 0-18 previous)

Improving equality and inclusion

- Using PHM to proactively identify patients and address areas of inequalities and target our response through Places and local neighbourhood partnerships
- Physical health screening and support services to be offered equitably to residents with poor mental health

Whole person care, including mind and body integration

- Integrate multi-sector mental health expertise within Primary Care Networks to knit together support and provide easy-to-access help while also upskilling primary care teams.
- Multi-agency care planning around what people need, including housing, employment, education, social isolation, and welfare support, delivered through a 'One Team' approach to community based mental health services focused on those with SMI and complex needs
- Transform complex care pathways to improve outcomes and continuity of care, e.g., eating disorder services, dual diagnosis pathways for mental health and substance misuse

Proactive management of our urgent and emergency response

- Extend the Urgent Community Response offer to include mental health nurses, with a 2-hour response
- Agencies coordinate data systems to identify individuals/communities at high risk and offer proactive support to meet needs before reaching crisis point
- Improve flow through urgent and emergency care pathways, reducing use of independent sector beds and eliminating out of area placements, by developing more alternatives to admission and integrating mental health expertise within police and ambulance call outs.
- Improve our inpatient environments and ensure beds are available when clinically required, but stays will be shorter and there will be less requirement for hospital stays under the Mental Health Act

Strengthen our workforce

- 5-year multi-sector mental health workforce strategy and a costed plan that meets future service ambitions, including the development of career pathways for people with lived experience of poor mental health and increasing apprenticeships within the sector

Build on strong collaborations and a culture of co-operation

- Fully functioning Provider Collaborative, working across all sectors to add value

3. Mental Health Services – Our Priorities for 2023/24

Theme	Ambitions	Service Provision
Changing how we support people in the community	Our community-based MH offer has been developed with the aim to provide more integrated services for people with mental health needs in the community. This involves new care models, with better integration and coordination between the range of different NHS mental and physical health services, and other services (for example, social care) that an individual may need. This includes firming up additional pathways including eating disorders and rehabilitation and fully transforming to a One Team approach across primary care and specialist MH services. This will really support those people in the community with a range of MH needs where these were previously unmet and at a much earlier stage. We want people to get the support with what matters most to them and services will help people with money, work and housing. Access to services close to home in the community with an early intervention approach remains a top priority bolstering both LTP and non LTP services and such as early intervention in psychosis, employment support	**Community MH Transformation** **Early Intervention in psychosis** **IPS-Employment support** **Adult Eating Disorder** **Live experience**
Urgent & Emergency Care	With the increasing pressure on our mental health UEC services we want to expand the range of services that will better help people in their local community to intervene early, prevent admission and keep people at home for longer. These will include the expansion of safe havens and the increased use of crisis beds. We will make it easier for the public to speak to a mental health professional as quickly as possible for advice, guidance and intervention via NHS111 with the ability to self-define if they are in crisis. We will support local Police and Ambulance colleagues with specialist MH expertise to help them to help our residents to access the right level of care in the right place and avoid unnecessary detention and or admission to a local hospital. We want only those that need it to be admitted to a MH bed and for the length of time that is needed and aim to reduce the number of people in a MH bed outside of our area to none. To do this we will ensure there is good flow in and out of our impatient units and we will work with our partners to reduce the number of people wating to be discharged who are clinically ready.	**Safe haven expansion** **Crisis beds** **MH & Ambulance offer** **NHS 111 MH option** **Inpatient Flow** **Out of Area Placements**
Early support	People with common mental illnesses such as anxiety, depression, panic disorders, phobias, OCD and PTSD have been well treated through our Talking Therapies service for nearly 15 years however we know more people need this support than access it.	**NHS Talking Therapies**
Health Inequalities	Mental illness is closely associated with many forms of inequalities. Health inequalities are avoidable and unfair differences in health status and determinants between groups of people due to demographic, socioeconomic, geographical and other factors. Health inequalities can mean reduced quality of life, poorer health outcomes and early death for many people. People living with SMI experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population and research shows the gap is widening. In Frimley this gap is between 15 and 18 years. We want to build on the great work that has been done on delivering physical health checks to 58% of people with a SMI and both increase uptake and review quality of these. We will outreach into communities and work with our Voluntary and Community Organisations to understand how we need to engage better with people from communities that are easy to overlook and make it easier for them to get the care they need. We will work with parts of the population such as those with dementia and perinatal mental health needs to understand why we are not seeing the number of people using services as we expect; this will be key in increasing the uptake into these services. We are very aware that we have long waits for neurodiversity assessments and want to support those waiting through case reviews. We will also work with colleagues across the LDA & CYP portfolio to complete a deep dive into neurodiversity. Sadly, we are still seeing people ending their life by suicide and will continue our suicide prevention initiatives through our places and increase the coverage of bereavement support across Frimley. We will continue to work with our Local Authority and VCS colleagues to provide services targeted to those who are homeless (rough sleepers)	**Physical health checks** **Dementia** **Neurodiversity** **Suicide prevention** **Perinatal** **Rough sleepers**
	Across Frimley there are three separate processes to access section 117 aftercare, and we have been reviewing these clients across parts of Frimley to make sure the care/ packages of support they are getting are delivering what they need. These reviews have had a significant impact on the quality of life of clients in providing care in the least restrictive way. Despite this, there is need to review the various processes in Surrey and Hampshire to ensure an equitable approach and manage variation in outcomes.	**Section 117 Aftercare**

4. Primary Care – Strategic Context

General practice and primary care services continue to be at the heart of communities with thousands of people benefiting from advice and support every day. However there are signs of discontent with these services from our population with insights showing a poorer experience being reported.

At the same time as the public are reporting a poorer experience, our primary care teams morale is low and capacity is stretched, leading to concerns around the stability of general practice services.

Despite this, new models of care have emerged with the adoption of population health principles, the multiplicity of new skills and roles through workforce development, and the positive adoption of new technologies. This illustrates the agility and flexibility that general practices working together can achieve.

General practice resilience will continue to be a key area of focus, particularly for smaller practices, and those with workforce and estates challenges. A focus across all workstreams will be around maximising existing offers and ensuring new initiatives are evaluated and embedded.

Over the next five years primary care networks and general practices will develop a model with greater resilience, fit for the future.

In Frimley, a population based model of care has framed the digital offer, workforce development and impact of understanding better the needs of our populations using segmentation. In early 2022, the publication of the Fuller Stocktake report provided a nationally recognised framework which aligns well with our local plans.

The five year plan for general medical services in Frimley is focused on existing key workstreams:

- Access including urgent same day primary care
- PCN development
- Population health management
- Digital adoption
- Workforce development

Enabled through aligned programmes such as:

- Analytics and insights
- Communication and engagement
- Estates and premises

In line with the national Primary Care Recovery Plan, the programme will be reviewed more fully, and final decisions taken on the scope for 2023/24, along with any new areas that will need to be developed in year.

4. Primary Care – Key Challenges

Key challenges setting out the current position:

- **Demand** in general practice is at unsustainable levels, with the complexities of an ageing population and higher levels of anxiety and mental health conditions further increasing demand. The challenge to meet the demand levels has led to reported poorer experiences by patients, with the total number of appointments in Frimley general practices increasing from Jan 22 to Jan 23 by 29%
- **Workforce** is stretched to capacity and the wellbeing of our teams is of concern with increasing levels of turnover and recruitment challenges. Across the staff groups, this illustrates a significant difference to national rates of staff per 100,000 patients:
- The proportions of same day and pre-booked **activity in services has shifted** with more rapid same day care being used, restricting the capacity for management of chronic conditions and preventative care. The Frimley system currently use 4% more appointment capacity for same day activity than the south east region, reflecting that more capacity is being used for urgent care than before, hence reducing the capacity for chronic or complex management and prevention of patients.
- **Premises capacity and quality**, alongside risks around ownership models, is restricting building additional capacity or having the appropriate space to integrate with wider teams, to build resilience and a wider offer to the population. Currently, with the limitations on capital investment and antiquated Premises Cost Directions, this remains high risk.
- The adoption of **digital opportunities** has been at pace and not welcomed by all staff and patients, and to deliver services efficiently with available resources the digital opportunities are key. A further challenge in progressing the digital opportunities is to address the time needs from services to enable effective change, during periods of low morale in staff, high demands from patients, and high turnover of staff in practices.
- The **public narrative** is currently negative around general practice. We need to engage and communicate clearly to patients about services changes, including how they can best prevent poor health and self care. The general support built under the pandemic for NHS services has dissipated, so working to build the respect for our teams and engage people in positive interactions is an ambition, resulting in improved experience, reduced staff turnover, and a healthier population.
- **Funding** remains of concern and with a new GP contract anticipated for 2024/25, the fifth year of the current five year deal needs to address these challenges. It must also recognise the development of the Integrated Neighbourhood Team evolution, to focus on bringing services together across populations to reduce inequalities and deliver better outcomes for people.

4. Primary Care – Our Five Year Priorities

- **Increase capacity** by investing to develop and test at scale models
- **Increase workforce capacity and skills mix** including support from non-clinical roles where appropriate for patients' needs
- **Improve premises** through the development of PCT Estates Toolkits reflected in the system estates plan and ensure a clear robust investment programme is ready for available investment
- **Releasing capacity** through a consistent adoption of digital technology, effective communication and through better use of available space, maximising existing facilities
- **Adopt digital to support people** getting the right care for their needs early in their journey and delivery clinical capacity where most needed
- **Self care and alternatives to general practice** including using Community Pharmacy, Dentistry and Optometry services, self presenting services and digital enablers such as Frimley Healthier Together
- **Continue to engage and communicate with our residents** including supporting PCNs and practices to improve their communication with patients, and co-designing service improvements in neighbourhoods
- **Population health management** to drive proactive care, working in partnership with others to improve health and wellbeing and reduce health inequalities
- **Continue to support PCN development** to develop "at scale" models of care based on local population needs, delivering on the ambitions from the Fuller Stocktake report around integrating neighbourhood teams and encouraging integration of primary care within and across rehabilitation pathways through an MDT approach
- **Fairer funding** to better align primary care funding with our understanding of the needs of our population, taking a no loser approach

4. Primary Care – Our Priorities for 2023/24

The plan below is focused on priority workstreams for the coming year; this is based on local priorities and the requirements set out in the General Practice Recovery Plan 2023/24. Our core areas of focus are on access, capacity and demand, digital, workforce and engaging with our public.

Access, Capacity and Demand	Digital	Workforce	Engage with Population and Communities
Increase use of minor illness offer in community pharmacy	Implement the front door digital offer including online consultation, video consultation and digital telephony	Review and develop the ARRS workforce plan for 2023/24, including the new ARRS roles and planning ahead to new GP contract	Co-design with our people support wider adoption of digitally enabled services approaches
Review and deliver primary care led urgent care services in the community	Clearly define the GP IT operation model	Deliver and develop the flexible workforce pools for GP and nursing	Evaluation and learn from communication with our population on the offer from general practice
Delivery of at-scale models of care, focused on improved access and support for	Maximise the opportunity through remote management opportunities from remote monitoring and recall via SMS models	Increase the number of apprenticeships in the primary care workforce	
Establishment of the General Practice Alert System aligned to OPEL		Develop a programme of education on workforce culture, staff wellbeing and freedom to speak up	
Implement and support the insights tool for general practice (Insights Version 2)			

4. Primary Care – Dependencies and Risks to Delivery

Dependencies	Risks
Workforce recruitment to the ARRS plans is successful and turn over is minimised	Practice resilience with the impact of general practice
Shared vision to deliver the ambitions across all practices and wider primary care providers	Premises and physical space for service delivery
Planned care, urgent care and community integrated interdependencies	Service demand restricting transformation
Transformation driven by analytics and evidence through the provision of the insights driving change for improvement	

4. Primary Care – Community Pharmacy, Optometry and Dental Services

Delegated Responsibility

On the 1 April 2023, ICBs took on delegated responsibility for commissioning pharmacy, general ophthalmic, and dental (POD) services from NHS England.

This is a significant milestone and supports the long-term and continuing ambition to put decision-making at as local a level as possible to meet the 'triple aim' of *better health for everyone, better care for all patients, and efficient use of NHS resources*, both for local systems and for the wider NHS.

The delegation of direct commissioning functions is a key enabler to realising this ambition. By giving ICBs responsibility for a broader range of functions, they will be better able to design services around the needs of their local communities. That is what integrated care is all about; joining up care and targeting our resources where they are needed most.

Supporting the safe delivery of these functions will also see some staff transferring from NHS England to ICBs by July 2023. Their expertise and knowledge will be vital in the smooth transfer of these services to systems and to help design effective operating models in the context of a wider range of responsibilities. NHSE recognise that systems will take control of commissioning functions as services remain under pressure in many parts of the NHS, and it is their commitment to continue to work hand in hand with ICBs to ensure this change can deliver on its promise for patients and for our network of providers.

Frimley's View

Giving ICBs responsibility for direct commissioning is a key enabler for integrating care and improving population health.

It gives the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.

Patients will receive the **right care at the right time in the right place**.

Current Issues

- Pharmacy unplanned closures and/or reducing hours
- Dental access & backlog
- Workforce challenges
- Contract lever limitations
- Management of stakeholder concerns
- Significant inequalities
- Quality oversight; risk that contractors are not compliant with registration/contractual requirements
- Financial challenges

4. Primary Care – Community Pharmacy, Optometry and Dental Services

Dental Services

The focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

- Maximising access to NHS Dental Services
- Deliver commissioning pipeline and mobilisation of new services prioritising:
  - Mandatory Dental Service (MDS) Orthodontics in HIOW, BOB & K&M by Apr-23.
  - Pre-procurement work for 2023/4 for Dental Electronic Referral System
  - Special Care & Paediatrics & interdependent services, preparation for re-commissioning in line with emerging Provider Selection Regime by Apr-24.

- Further develop Oral Health Profiles with Consultants in DPH to establish commissioning priorities & opportunities
- Secondary care dental providers assurance of elective recovery plans
- Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards
- Implementation of Restoration & Recovery workstreams
- Implementation of Local Professional Network (LPN) Transformation Programmes supported by non-recurrent investments that continue to drive integration with PCNs.
- Implementation of any agreed national dental system (contract) reform requirements in line with NHSE/I statutory responsibilities.
- Implementation of any agreed national commissioning frameworks for community pharmacy in line with NHSE/I statutory responsibilities.

4. Primary Care – Community Pharmacy, Optometry and Dental Services

Community Optometry

Elective Care

Within the ICS, the North and South have slightly different services. In the South we are doing a small amount of direct elective care referrals via a provider called PES. In the North we currently do not have any route for direct referrals from optometrists currently set up

Urgent Care

In the South of our geography, optometrists are able to directly send patients to the walk-in casualty clinic at RBH, whilst in the North they would be referred via the GP. We do have plans to begin direct referrals once Frimley Park Hospital's IT team has capacity to take this on as it will involve mobilising a new referral management system within the hospital just for eyes.

Benchmarking from neighbouring ICBs suggests that it takes about 6 months – 1 year for the service to be fully up and running. Plans are not yet fully worked up, as we have not been given the go ahead to begin this work as it is very dependent on Frimley Park Hospital IT team's capacity to take this on. There is first year funding available via NHSE for this change.

4. Primary Care – Community Pharmacy, Optometry and Dental Services

Community Pharmacy

Like GPs, community pharmacies and their teams are part of the NHS family. Every day about 1.6 million people visit a pharmacy in England. Community pharmacies are situated in high street locations, in neighbourhood centres, in supermarkets and in the heart of the most deprived communities. Many are open long hours when other health care professionals are unavailable. There are several different types and sizes of community pharmacies, ranging from the large chains with shops on every High Street or in edge of town supermarkets, to small individually owned pharmacies in small communities, in the suburbs and often in deprived areas or rural settings.

Our goal is to ensure Community Pharmacy remains as the centre of health care in the community. In addition to utilising the complete skills and competence of the entire pharmacy team working in the Community Pharmacy to deliver effective, sustainable and appropriate clinical care with the necessary digital infrastructure and tools to do so.

5-year settlement for the Community Pharmacy Contractual Framework (CPCF) expands and transforms the role of community pharmacies and embed them as the first port of call for minor illness and health advice in England. This Underlines the critical role of community pharmacy as an agent of improved public health and prevention, embedded in the local community

Key Deliverables	
Integrating Community and Primary Care Pharmacy Teams	Maximising our opportunities with the Pathfinders pilot (IP)
Supporting healthcare inequalities through targeted pharmaceutical care initiatives	Being agile when faced with closures (planned/unplanned), contractual changes and financial pressures
Expanding and utilising clinical skills	Working in tandem with regional and POD colleagues with planning
Balancing the need to drive local commissioning where possible (LCS) with the importance of focusing on core service	Building a sustainable financial model for Community Pharmacy through delegated functions

5. Community Health Services – Strategic Context

Community health services within the Frimley system are delivered by multiple providers, all of whom have a positive track record in service delivery. Providers include Berkshire Healthcare Foundation Trust, Frimley Health Foundation Trust and HCRG Care Group. All deliver a range of services including community nursing, intermediate care, frailty hospital at home (virtual ward), community wards, out of hospital care, urgent care, and specialist care such as therapies, heart function, respiratory, hearing and balance, sexual health and many more.

Traditionally there has been an integrated approach to service delivery including social care, primary care, and/or secondary care, plus the voluntary sector.

A key part of the community offering includes access to community beds both within a virtual- and bed- based setting.

The services are delivered in a variety of settings, including leisure centres and outpatient clinics (face to face and virtual), though a significant proportion take place in a patient's home. We care for the elderly, frail, and most vulnerable, in our community.

The NHS Long Term Plan (LTP) provides the national policy context for collaboration in the planning and delivery of services. It emphasises the need to 'boost care out of hospital' and have integrated teams of community and general practices working in primary care networks. The LTP committed additional investment into community health services for Urgent Community Response (UCR) and virtual wards. Both of these funding streams are now included in the Strategic Development Fund (SDF) investment, alongside many other services.

Approximately 15 million people in England have a long term health condition. Long term conditions or chronic diseases are conditions where there are currently no cures, which are managed with drugs and other treatment. These include, among others, diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

5. Community Services - Key Challenges

Quality and access

- Keeping patients well and safe in the community within the ever challenging financial environment
- Variation in the community service offer from North to South from historic commissioning arrangements
- Variation in waiting times
- Service variation (including service specifications)
- Lack of strategic approach to collaborative working with our Voluntary and Community Sector services to offer early intervention, prevention, and support at home, to avoid escalating needs
- How we ensure people understand the value of community health services and the role that we play in supporting and keeping patients in the community

Demand versus capacity

- Ageing population with complex care needs
- Significant challenge in how we support community health services recover from the pandemic and care for people with long covid; specifically waiting times and the urgent and emergency recovery plan
- Bed modelling suggests there may be a need for additional beds in our community facilities.
- Flow through the community beds, with support required from intermediate/reablement and social care

Health inequalities

- Deprivation has a huge impact on health; our communities in areas such as Slough and Rushmoor experience lower life expectancies, with a 15-to-20-year difference in life span

Finance

- Zero financial growth, but a growing older population
- End of SDF ringfenced and targeted transformational funding

Workforce

- Recruitment and retention

Integrated working

- Adopting new ways of working in an integrated way that is meaningful to all

Community estate

- The condition of our estates and the amount of space for improved facilities

5. Community Services – Our Five Year Priorities

Digital transformation

- Promoting remote monitoring in our community services
- Data to support demand versus capacity and areas of inequality
- Promoting the inclusion of community and social care in the shared care records
- Releasing productivity within teams

Developing community capacity

- Ensure that there is the most appropriate bed based provision supported by a virtual community hospital team on the Frailty hospital at home (virtual ward)
- Reduction of duplication in service provision

Transformation of services

- Review key pathways from a transformation perspective
- Review and redesign, as appropriate, the evidence based pathways that underpin the delivery of services that include community nursing and intermediate care.
- Development of integrated community pain pathway service, which needs to be supported by local data to improve the clinical offer
- Introduction of self referral across several community pathways e.g., MSK
- Shared back office functions across the system
- Develop a strategy of integration with VCSE, including joint commissioning procurement options to enable access to in-reach vulnerable and marginalised groups, and support prevention, promotion, and early intervention
- Integrated community and primary care teams at neighbourhood level

Estate

- Prioritisation of estate across community and primary care

Workforce

- Staff recruitment, retention, and wellbeing, including appropriate (clinical and support) staff development and career progression across the system

Health inequalities

- Equity of service provision and reduction of variation

Improving local access to the right expertise and care

- We want patients with complex needs to have better access to specialists located at community facilities delivering high quality local care, releasing hospital capacity for people who require acute care

5. Community Services – Our Priorities for 2023/24

- Reduce our **waiting times**
- **Increase capacity** within community services
  - Make every contact count such as the use of hubs and one-stop services to ensure value adding patient care
  - Move to needs-based care and support e.g., patient initiated follow ups where appropriate
  - Increase the use of remote monitoring
  - Manage our workforce in line with recruitment and retention plans
- Continue our ongoing **transformation** programmes to ensure sustainable and efficient use of resources e.g., heart function, diabetes, and intermediate care
- Improve **system flow**
  - Ensure effective use of in reach, which is interdependent with Urgent Community Response, frailty services, and virtual wards
  - Reduction in 'lost bed days', including length of stay
  - Increase usage of virtual ward
  - Increased numbers of community beds
  - Trusted assessment models
  - Making every day matter
- Improving **access**
  - Self referral to key services such as MSK, hearing and balance, and falls
  - Reducing unwarranted variation
- Review of Diagnosis and Treatment Centre (DATC) to prevent duplication within community/primary care settings
- Agree areas of duplication that will need longer term input such as community front doors

5. Community Services - Dependencies, Enablers, and Risks to Delivery

Dependencies

- Understand contractual barriers
- PCN/ DES need community to support to deliver
- Estate availability for colocation
- Financial investment will meet the demand of increasing ageing population, as there will be 50% more over 80-year-olds in the next 10 years
- Alignment of agendas across different providers
- Community underpins all key LTC workstreams

Enablers

- Digital capability and support
- Support of Place-based partners
- Integrated working with primary care
- Community nursing capacity and demand tool

Risks

- Workforce recruitment and retention
- Capacity and demand across the local system
- Investment does not meet the demand of our increasing ageing population
- Ageing population with more complex care needs
- Support of Place-based partners*
- Integrated working with primary care*
- Pressure on community nursing and intermediate care

* can be a risk and enabler

6. Major Health Conditions – Executive Summary

Introduction

The Frimley Joint Forward Plan is a comprehensive strategy for improving the health and wellbeing of people living across the Frimley geography. It aims to ensure that everyone in the area receives high-quality, person-centred care and support, and that the healthcare system is sustainable, efficient, and effective. One of the key areas of focus in the plan is major health conditions, including cancer, stroke, cardiovascular disease, diabetes, and respiratory illness.

Each of these major health conditions is covered in a separate subsection in the plan, and each subsection sets out the strategic context for that condition, progress made since the NHS Long Term Plan was published in January 2019, priorities for the next five years, priorities for the year ahead, and dependencies, enablers and risks.

Cancer: Strategic Context, Progress, and Priorities

The Cancer subsection of the plan highlights the importance of early detection, treatment, and support for people living with cancer. It notes the progress made in recent years in improving cancer outcomes and reducing mortality rates, but also acknowledges the challenges that remain, including the need to address inequalities in access to care and the impact of the COVID-19 pandemic.

The priorities for the next five years include improving cancer screening rates, expanding access to innovative treatments, and developing more integrated and person-centred care pathways. The priorities for the year ahead include enhancing the use of technology to support cancer care and developing new models of care to improve outcomes for patients.

Stroke: Strategic Context, Progress, and Priorities

The Stroke subsection of the plan focuses on the need to improve the prevention, treatment, and rehabilitation of stroke patients. It notes the progress made in recent years in reducing the incidence and impact of stroke, but also highlights the ongoing challenges, including the need to improve access to timely and effective treatment.

The priorities for the next five years include developing more integrated and person-centred stroke services, improving the quality and safety of care, and enhancing support for stroke survivors and their families. The priorities for the year ahead include implementing new models of care, developing new pathways for rehabilitation, and improving access to psychological support.

Cardiovascular Disease: Strategic Context, Progress, and Priorities

The Cardiovascular Disease subsection of the plan highlights the importance of preventing, detecting, and managing cardiovascular disease, including heart disease and stroke. It notes the progress made in recent years in reducing mortality rates and improving outcomes for patients, but also acknowledges the challenges that remain, including the need to address inequalities in access to care and the impact of the COVID-19 pandemic.

The priorities for the next five years include improving cardiovascular risk assessment, expanding access to innovative treatments, and developing more integrated and person-centred care pathways. The priorities for the year ahead include enhancing the use of technology to support cardiovascular care and developing new models of care to improve outcomes for patients.

Diabetes: Strategic Context, Progress, and Priorities

The Diabetes subsection of the plan focuses on the need to improve the prevention, detection, and management of diabetes, including type 1 and type 2 diabetes. It notes the progress made in recent years in improving diabetes care and reducing complications, but also highlights the ongoing challenges, including the need to address inequalities in access to care and the impact of the COVID-19 pandemic.

The priorities for the next five years include improving diabetes prevention and early detection, expanding access to innovative treatments, and developing more integrated and person-centred care pathways. The priorities for the year ahead include enhancing the use of technology to support diabetes care and developing new models of care to improve outcomes for patients.

Respiratory: Strategic Context, Progress, and Priorities

The Respiratory subsection of the plan focuses on the need to improve the prevention, detection, and management of respiratory illness, including asthma, chronic obstructive pulmonary disease (COPD), and lung cancer. It notes the progress made in recent years in improving respiratory care and reducing mortality rates, but also highlights the ongoing challenges, including the need to address inequalities in access to care and the impact of the COVID-19 pandemic.

The priorities for the next five years include improving respiratory prevention and early detection, expanding access to innovative treatments, and developing more integrated and person-centred care pathways. The priorities for the year ahead include enhancing the use of technology to support respiratory care and developing new models of care to improve outcomes for patients.

6a. Cancer – Strategic Context

Improving cancer care

Cancer survival in England has lagged behind similar nations. In order to support improving this position, the long term plan asks the NHS to improve the proportion of patients diagnosed at stage 1 and 2 from 50% to 75%. The challenge for our system is to make improvements in cancer survival and patient experience, in the context of a number of issues. The main challenges include:

Population Growth

The growth in population has led to increased demand for cancer treatments. This trend is particularly noticeable in urban areas where population growth is highest.

Ageing Population Resulting in Rising Cancer Diagnoses

An ageing population has resulted in more cancer being diagnosed that may be amenable to treatment . The elderly population also has higher potential for co-morbidities that add to the complexity of diagnosis and treatment.

Increased Availability of Treatments

The availability of new and advanced treatments has resulted in increased demand for cancer services. As medical technology advances, more patients are seeking treatments that were previously unavailable or inaccessible. The costs of these new treatments in terms of additional infrastructure, equipment, workforce and medicines are a significant challenge.

Demand for Cancer Treatment Related to Lifestyle Factors

Obesity, diet and smoking are significant risk factor for cancer, and drive increases in cancer incidence.

Large Cancer Backlog Resulting from the Pandemic: Reducing the Backlog to Meet NHS Targets

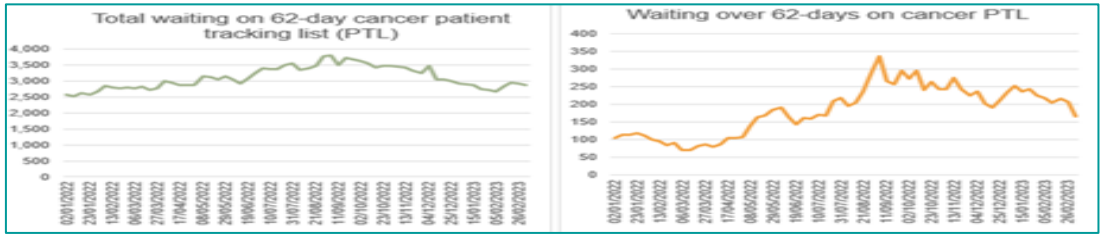
The pandemic has resulted in a longer times to diagnosis and treatment and more patients waiting at any given time. These needs to be reduced in line with NHS targets. There is a potential for longer times to diagnosis to increase morbidity and mortality for patients with cancer.

Our system has begun to recover well compared to other systems, however increasing cancer survival and reducing times to diagnosis and treatment priority for our system. This requires a collaborative effort from healthcare providers and staff to ensure that patients are identified, diagnoses and receive effective timely care. Working with tertiary providers, the Surrey and Sussex Cancer Alliance, and with support from Macmillan and CRUK, we aim to address this through a variety of approaches across the pathway.

South East - Cancer Recovery and Performance Dashboard By Provider

NHS

		Recovery					Cancer Waiting Time Performance		
		1a. Levels of Urgent Suspected Cancer Referrals seen (Latest month)	1b. Levels of Urgent Suspected Cancer Referrals seen (Cumulative - March 2020 to latest month)	2a. Levels of First Treatments for Cancer (Latest month)	2b. Levels of First Treatments for Cancer (Cumulative - March 2020 to latest month)	3. Proportion of Urgent GP Cancer PTL waiting >62 days	4. Faster Diagnosis Standard Performance	5. 31 day First Treatment Performance	6. 62 day Urgent Referral to 1st Treatment Performance
	Benchmark	G:>=110% A:100-110% R:<100%	N/A	G:>=110% A:100-110% R:<100%	N/A	G:<=6.4% A:6.4-8% R:>8%	G:>=75% A:70-75% R:<70%	G:>=96% A:94-96% R:<94%	G:>=85% A:77.5-85% R:<77.5%
	Period	Jan-23	Mar-20 - Jan-23	Jan-23	Mar-20 - Jan-23	we 05 Mar 23	Jan-23	Jan-23	Jan-23
	Providers meeting standard	18/18		7/18		7/18	5/18	4/19	1/19
Kent and Medway	Dartford And Gravesham	157.2%	123.9%	121.5%	96.1%	8.1%	66.8%	98.9%	49.1%
	East Kent Hospitals University	126.3%	113.4%	98.5%	100.2%	5.2%	53.8%	96.2%	63.9%
	Maidstone And Tunbridge	147.6%	111.4%	97.6%	92.2%	4.0%	69.7%	98.3%	85.1%
Frimley	Frimley Health	132.6%	104.4%	108.2%	104.1%	5.6%	59.7%	91.2%	46.1%
Surrey Heartlands	Royal Surrey	117.2%	111.2%	104.3%	101.9%	6.2%	87.5%	94.9%	68.9%
	Surrey And Sussex	148.2%	111.1%	91.0%	100.2%	7.7%	56.0%	95.0%	63.6%
Sussex Health and Care Partnership	East Sussex	115.0%	108.9%	104.8%	107.2%	4.6%	72.3%	94.0%	67.5%
	Queen Victoria Hospital	146.1%	126.1%	137.7%	124.9%	4.9%	82.3%	92.4%	80.0%
	Sussex Partnership							0.0%	0.0%
	University Hospitals Sussex	131.1%	106.2%	99.3%	100.6%	7.2%	59.2%	84.3%	49.3%
Buckinghamshire, Oxfordshire and Berkshire West	Buckinghamshire	148.6%	124.9%	95.6%	102.8%	7.4%	60.3%	78.9%	55.0%
	Oxford University Hospitals	139.2%	106.2%	125.9%	126.4%	9.4%	77.7%	72.8%	55.0%
	Royal Berkshire	120.7%	104.6%	76.4%	91.1%	10.9%	67.9%	94.9%	65.2%
Hampshire and Isle of Wight	Hampshire Hospitals	137.2%	106.6%	124.4%	100.3%	8.3%	72.6%	91.7%	55.9%
	Isle Of Wight	125.1%	95.4%	75.1%	98.6%	9.4%	59.4%	95.1%	53.5%
	Portsmouth Hospitals University	127.4%	97.8%	120.2%	98.5%	7.7%	75.9%	88.6%	49.0%
	University Hospital Southampton	136.3%	111.3%	114.0%	105.4%	10.4%	70.0%	82.3%	50.0%
	Region overall	133.1%	109.0%	105.6%	102.9%	7.2%	65.8%	88.8%	58.8%
	England overall	124.6%	104.7%	106.4%	98.2%	7.8%	67.0%	88.5%	54.4%



Frimley Health and Care

NHS Surrey and Borders Partnership NHS Foundation Trust

NHS Berkshire Healthcare NHS Foundation Trust

NHS Frimley Health NHS Foundation Trust

NHS Frimley Integrated Care Board

6a. Cancer – Priorities

Delivery Focus Areas

Prevention and screening

- Reducing levels of smoking to reduce individual cancer risk
- Supporting people to manage their weight to healthy levels
- Ensuring that current screening programmes (bowel, cervical, breast) are as effective as possible
- Implementing new screening programmes (currently lung)
- Rolling out genomic testing
- Implementing surveillance programmes to reduce risk in large groups such as liver, BRCA, pancreas

Early presentation for diagnosis

- Use of public campaigns to encourage people with concerning symptoms to come forward
- Providing education for clinical staff to support new developments and increase appropriate referrals/safety netting

Effective and timely diagnosis and treatment

- Increase diagnostic capacity to meet growing demand
- Implement new diagnostics modalities as they become beneficial
- Streamline pathways in secondary care to reduce the time it takes to diagnose and treat patients
- Patient navigation through pathways
- Ensure that surgical and chemotherapy treatment capacity is able to meet demand
- Expand chemotherapy preparation capacity to meet current and future needs
- Ensure that the most effective treatments are being utilised and are continuously reviewed in order to deliver the best outcomes for patients

Support for patients before, during and after treatment

- Make prehabilitation available to all patients that could benefit from interventions to improve outcomes of treatment
- Provide advice for patients on choices of treatment and coping during treatment
- Provide practical advice and support for patients in relation to non-clinical issues such as financial, social
- Provide support for patients after treatment is complete
- Ensure that patient supported follow up pathways are maximised to allow patients to manage their own health as appropriate

Opportunities, Priorities and Benefits 22/23

Prevention and screening

To reduce cancer incidence and improve cancer detected through screening

- Extend smoking cessation offer
- Initiate roll out of targeted lung health checks pilot
- Digital weight management scheme roll out Improve screening uptake in breast, colorectal, and cervical
- Review liver surveillance and develop improvement plan,
- Ensure BRCA screening in place
- Identify and target areas with lower presentation rates and worse outcomes for bespoke measures to increase screening uptake

Early presentation for diagnosis

To deliver earlier diagnoses and increase survival

- Local implementation of national campaigns on coming forward with concerning symptoms
- GP leader campaigns to the public
- Referrer education focusing on suspected gynaecology, colorectal, and urological cancer
- Implement iRefer to support diagnostics decision making and direct access pathways

Effective and timely diagnosis and treatment

To reduce the time it takes to diagnose an treat cancer using the most effective current therapeutics

- Provide additional diagnostics capacity at Heatherwood Hospital
- Improve access to PET-CT
- Implementation of a Cytosponge service (subject to national approval)
- Progress plans for a Community Diagnostics Centre in Slough and a spoke in Aldershot
- Restart one stop prostate diagnostic services
- Restore 7 day request to report turnaround times for diagnostics
- Ensure patients have a Fit test result considered prior to referral for suspected colorectal cancer
- Complete pathway reviews and actions for colorectal, gynaecology, and urology

Support for patients before, during and after treatment

To improve patient experience and reduce impact on the local population

- Increase the number of patients who receive a health needs assessment when they are diagnosed with cancer
- Increase the number of patients who receive a cancer care review
- Increase the level of signposting and other support for patients during and after cancer treatment

6a. Cancer – Our Five Year Priorities

5 year Opportunities, Priorities and Benefits

Prevention and screening

To reduce cancer incidence and improve cancer detected through screening

- Reduce smoking to below national levels
- Make measurable reduction in levels of obesity
- Improve screening uptake in breast, colorectal, and cervical to top decile
- Deliver targeted lung health checks in line with the national programme
- Implement new screening services as they become available

Early presentation for diagnosis

To deliver earlier diagnoses and increase survival

- Local implementation of national campaigns on coming forward with concerning symptoms
- GP leader campaigns to the public
- Referrer education focusing on suspected gynaecology, colorectal, and urological cancer
- Implement iRefer to support diagnostics decision making and direct access pathways

Effective and timely diagnosis and treatment

To reduce the time it takes to diagnose and treat cancer using the most effective current therapeutics

- Return to meeting constitutional waiting time standards
- Utilise diagnostics in community settings as far as possible
- Provide an alternative to diagnostics and treatment services delivered by Mount Vernon Cancer Centre (including chemotherapy and radiotherapy)
- Restore 7 day request to report turnaround times for diagnostics
- Complete pathway reviews and improvement actions for any pathways not meeting the required standards
- Expand capacity for aseptic preparation of chemotherapy to meet growing needs
- Deliver continues quality and outcomes reviews to increase survival where improvement potential identified

Support for patients before, during and after treatment

To improve patient experience and reduce impact on the local population

- Ensure that all patients who wish for a health needs assessment when they are diagnosed with cancer receive one
- Ensure that all patients who wish for a cancer care review by their GP at the appropriate time receive one
- Provide improved psychosocial support for patients
- Provide effective signposting to support resources and information for all patients
- Show improved patient feedback in all measures

6a. Cancer – Dependencies, Enablers, and Risks to Delivery

Risks associated with 23/24 plans

Risks/Issues	Mitigation
Patients referred do not fit NG12 criteria, so referrals increase but less likely to pick up cancers.	GP training programmes target identified areas of action required via referral audit
Staffing and facilities capacity to deliver lung and prostate projects	Use of external providers
Disruption due to winter/covid pressures	Mitigated via suite of actions as per the winter plan to be developed in Q1
Critical care capacity due to covid/influenza pressures	Use of ring-fenced critical care capacity at single site and provision of enhanced care at surgical hub site if required
Workforce gaps in diagnostics and treatments, particularly theatres, anaesthetics, histopathology, radiographers and radiologists, GI endoscopists	Workforce plan included recruitment and retention support including overseas recruitment of radiographers and sonographers, and increased training places for ODPs, sonographers and reporting radiographers. Further development of the CNS pipeline.
Large increase in prostate referrals together particularly the prostate catch up project	Taper catch up project roll out. Rescheduling of urology activities around any campaigns
Supply chain issues for chemotherapy drugs	These are managed by pharmacy and procurement teams, sourcing alternatives where available and planning any actions required as a result of total losses for a period of time
The cancer referral rates rise further without commensurate increase in diagnoses	Audit of referrals and GP education where referrals do not meet criteria and diverting activity from routine work as needed
Recruitment to short term transformation funded posts to support the most challenged pathways	Aim to support 2-year posts.
Ability to recruit and retain consultant histopathologists, GI endoscopists, hysteroscopists and breast radiologists.	Workforce plan includes actions to address, use of agency staff.
Risk to ability to manufacture chemotherapy due to workforce gaps and facilities availability	Workforce support for the development of specialised pharmacy staff pipeline. New aseptic preparation unit in planning stage.

Forward risks

- Workforce capacity across all professions
- Chemotherapy aseptic preparation capacity
- Diagnostics capacity
- Revenue funding for additional workforce and non-pay costs
- Capacity and capability for change and improvement
- Tertiary centres capability including review of Mount Vernon Cancer Centre
- Capacity disruption e.g., the pandemic

Dependencies

- Surrey and Sussex Cancer Alliance
- Close working across primary and secondary care
- Workforce plan delivery
- Ongoing work with Connected Care
- Close working across primary and secondary care
- Macmillan services
- The national aseptics services programme

Enablers

- Population health analytics
- CRUK
- Local clinical leadership
- Frimley Excellence QI
- Digital transformation support for iRefer implementation
- Capital developments to deliver CDC activity increases

6b. Stroke Services and Neurology – Strategic Context

The NHS Long Term Plan (LTP) identified stroke as a clinical priority. The milestones for stroke care articulated within the LTP include developing improved post-hospital stroke rehabilitation models, delivering a ten-fold increase in the proportion of patients who receive a thrombectomy after stroke and delivering improved thrombolysis performance with access to all patients who could benefit. Integrated Stroke Delivery Networks (ISDNs) are an integral part of delivering the LTP commitments for stroke.

The Frimley / Surrey Heartlands Integrated Stroke Delivery Network (ISDN) was established in April 2021, with the overarching aim to improve the quality of stroke care by improving clinical outcomes, patient experience, and patient safety. The ISDN brings together key stakeholders and partners to collectively agree a strategic plan of work to facilitate service improvements across the whole stroke pathway, ensuring a patient centred, evidence-based, approach to delivering transformational change in line with the ISDN National Stroke Service Model. The vision of the Frimley / Surrey Heartlands ISDN is to support the development of high quality and equitable stroke services to achieve the best outcomes and experience for patients and to ensure the delivery of the NHS Long Term Plan ambitions to improve stroke care. The ISDN will ensure that stroke services are provided in an equitable, safe, and efficient way, enabling the development of improved service standards so that a consistent experience is provided for patients and carers across providers and organisations. Areas of unwarranted variation will be identified and addressed so that there is equity in access to services and treatment.

At the heart of the ISDN is Frimley and Surrey Heartlands ICSs' commitment to work together as a system to transform public services and secure consistent, sustainable, high quality physical and mental health and care, and the best use of financial resources for local populations in the long term. The opportunity, working across both ICSs, is to come together to improve stroke care across the full pathway, addressing any challenges as a wider system and enabling us to achieve 'more than the sum of the parts'.

The ISDN has thus developed 3 key workstreams:
(i) Prevention,
(ii) Acute and Urgent Care,
(iii) Rehabilitation and Life after Stroke

These have been formed from a diverse Clinical Reference Group. The priorities of each workstream are underpinned and driven by various national documents including the National Stroke Service Model (2021), The Stroke Integrated Community Stroke Service Model (2022), Stroke GIRFT Report (2022), and the Rightcare Stroke Toolkit (2022).

Key issues currently affecting the stroke pathway at the front end include (i) removal of the 4 hour ED target with Trusts focused on avoiding breeches to the 12 hour target; (ii) stroke beds not being ring fenced within the acute stroke centres (iii) bed capacity and pressure issues affecting all sites. At the back end of the pathway, these targets are affected by (i) delays with social care packages (ii) delayed transfer to inpatient rehabilitation (iii) variable input from community teams due to differences in rehab availability e.g., differences in ESD criteria and workforce shortages. Within the rehabilitation and life after stroke pathway, one of the most complex issues is that NHS-funded care is commissioned and delivered by multiple organizations with gaps in service provision and complex workforce shortages.

6b. Stroke Services and Neurology – Our Five Year Priorities

Over the next five years the ISDN's ambition is to ensure the provision of quality, equitable, stroke service provision so that residents will receive the right care at the right time and in the most appropriate place. This includes access to needs-led rehabilitation, secondary prevention advice, and life after stroke support.

Priorities for the next five years include:

Stroke Prevention - Due to the considerable overlap between cardiovascular disease and stroke prevention activities, the ISDN's prevention focused work is joined up with the cardiovascular disease programmes within the ICS and supporting primary and secondary prevention projects. From a secondary prevention perspective, the ISDN is working to improve consistency and clarity of secondary prevention advice post stroke and continuing to establish the ISDN-wide discharge standard that has been developed.

Rehabilitation and Life after Stroke – Frimley ICS are committed to delivering the Integrated Community Stroke Service Model (ICSS), improving the intensity and access to rehabilitation across their geographies and ensuring the integration of social care in the delivery of stroke rehabilitation. Working with the Regional Stroke Rehabilitation Quality Improvement (SQuIRe) Programme, Frimley Health and Care ICS have successfully bid for funding to catalyse delivery of the ICSS model. A Project Lead, working as part of the ISDN team, will be recruited to unpick the complex local commissioning landscape which is one of the key barriers affecting commissioning and delivery of the ICSS in the short, medium, and long term and deliver tangible change in respect to rehabilitation performance measures and integration with social care services, as well as a costed plan to deliver seven-day services. The project aligns with the ICSs collective ambition to work with people and communities to develop a shared response to the challenges faced. It will support the collaborative development of integrated teams that deliver personalized and preventative care, thereby 'reducing the differences in healthy lives lived' and ensuring the best possible health and wellbeing.

ISDN Stroke Survivor and Carer Panel – The newly formed Panel will be responsible for reviewing, scrutinising, and informing the ISDN's work plan, ensuring that the ISDN and stroke service providers learn from the views of people with lived experience of stroke, and that their experiences are taken into account in the planning, delivery, and evaluation of stroke services. Feedback mechanisms will also include the National PREMS project.

Acute and Urgent Care

(a) **SSNAP Performance** – maintaining strong SSNAP performance is key to providing assurance regarding the delivery of quality stroke services and supporting scrutiny of stroke service provision. The ISDN team is visiting each admitting stroke site with the aim of increasing the profile of stroke within each acute provider and supporting scrutiny of the pathway and broader understanding of the impact of receiving specialist care at the right time. The ISDN will also support, with improving links and collaboration between stroke teams and site teams to support discussions regarding stroke beds.

(b) **TIA Pathways** - the ISDN plans to work with the Stroke GP / Primary Care Leads to support getting people to the right place at the right time, including encouraging GPs to access rapid access services and/or direct referral to TIA clinic rather than transfer to an Emergency Department.

(c) **Pre-hospital Pathway** – a key objective is to transform the pre-hospital pathway and improve pre-hospital triage for suspected stroke and TIA patients in order to improve patient safety and outcomes, and help ensure that patients receive the right care in the right place. A nationally funded pre-hospital video triage 'proof of concept' pilot has commenced at Frimley Hospital. Over 23/24, the Frimley pre-hospital proof of concept video-triage pilot will complete and be fully evaluated, and provided the project has delivered positive results, the ISDN will work with Frimley to ensure the long term sustainability of this pathway

(d) **Thrombectomy Pathway** – the ISDN has established thrombectomy governance and pathway meetings with St Georges Hospital and Kings College Hospital to support improvements to the pathway. Areas of particular focus for Frimley will include ongoing progress towards implementation of the National Optimal Stroke Imaging Pathway (NOSIP) with increasing access to CT-Perfusion, maximising the use of the Rapid AI decision support tool and improving the efficiency and speed of repatriation from the thrombectomy hubs.

(e) **Wexham / Wycombe Stroke and TIA Pathway** – supported by the ISDN, Frimley ICS will ensure improvements in the shared pathway with Wycombe Hospital, ensuring equity of service provision for Frimley ICS patients.

6b. Stroke Services and Neurology – Our Priorities for 2023/24

Stroke Prevention

- Working with Frimley ICS CVD prevention workstream to support sustained improvements in the identification and treatment of hypertension and atrial fibrillation within the population. Support will be targeted where it's most needed, with the aim to reduce the unfairness some people experience in accessing stroke prevention advice.
- To work together with the ICS CVD prevention workstream, GPs, Community Pharmacy teams, and Public Health to promote and improve secondary prevention.

Acute and Urgent Care

- ***SSNAP and Critical Time Standards*** – ongoing scrutiny of performance targets with the development of performance improvement plans and targeted measures as appropriate.
- ***TIA Pathway*** **-** to work with the Stroke GP and Primary Care Leads to support getting people to the right place at the right time, including encouraging GPs to access rapid access services and/or direct referral to TIA clinic, rather than transfer to an Emergency Department.
- ***Pre-hospital Pathway*** – Frimley pilot to be fully evaluated with business case submitted and approved to enable long term sustainability of the pathway, so that pre-hospital video triage will be 'business as usual' within the stroke pathway. Pre-hospital video-triage is an innovative approach that is expected to support the ICS to address the impact of health inequalities. Studies have shown that the great majority of people experience a certain level of anxiety about hospitals that might revolve around the fear of pain, injury, blood and being under the control of strangers, whilst separated from their family. Active engagement of the family in the treatment process can play a pivotal role in successful recovery. Also, cultural, spiritual, and religious beliefs can impact on the use of healthcare services, which is a key consideration in respect to those patients from a BAME background. In this context, video-triage will enable patients/carers to communicate directly with a stroke specialist prior to hospital conveyance which may support patient/carer confidence in medical advice. In many cases, this initial conversation is likely to take place within a patient's home or other familiar environment, which is expected to reduce anxiety and increase confidence. In addition, video-triage offers the opportunity for a patient's family to support with history taking and, where English is not a patient's first language, this may be particularly helpful as the patient already knows and trusts them. Additionally, this pathway offers the potential to avoid conveyance to hospital in some cases which would prevent unnecessary inconvenience to families, and particularly benefit those patients from more deprived families, for whom travelling to hospital and the potential loss of income incurred would add a further burden.
- ***Thrombectomy Pathway*** – increasing access to CT-Perfusion, maximising the use of the Rapid AI decision support tool and improving the efficiency and speed of repatriation from the thrombectomy hubs.
- ***Wexham / Wycombe Stroke and TIA Pathway*** – clinical pathways, agreed in 2022, to be fully implemented with regular shared Clinical Governance meetings to ensure transparent sharing of pathway data and detailed discussion of pathway issues, review of any adverse incidents and clinical case discussion.

Rehabilitation and Life after Stroke

- SQuIRe Catalyst project lead will be recruited and this project will commence leading to the development of a costed transformation plan for implementation of the ICSS model that will be submitted to the appropriate ICS Board for approval. As part of this project, a data set and method for data collection will be agreed across all community stroke rehabilitation teams.
- SQuIRe funded Frimley focused quality improvement project entitled 'Life After Hospital - Empowering Stroke Survivors and their Carers through a Psychoeducation Session Before Discharge from a Post-Acute Stroke Rehabilitation Ward'.

ISDN Stroke Survivor and Carer Panel

- The panel will meet quarterly and Frimley ICS will engage with outputs from the panel as appropriate. Working closely with the ISDN's Stroke Survivor and Carer Panel will help ensure that the lived experience, views, and aspirations of local people and communities runs through the ISDN's work, including supporting people to sustain and improve their health and wellbeing and reaching out to those who are less well served by services and most at risk of health inequalities. In respect to the SQuIRe catalyst project, co-production will be integral to ensure a true reflection of patient need, so that the rehabilitation model will maximally support the populations served by the ICS.

Together, these priorities are expected to deliver improvements to the way stroke care is delivered, leading to the improved quality of stroke services and improved patient outcomes. There is no set rule for what counts as value in a 'Return On Investment' assessment but financial savings may include time savings (that can be translated into increased revenue) or reductions in appointments, diagnostics, and admissions. In this case, delivering these priorities are expected to lead to more improved, equitable, effective, and integrated stroke services that provide needs-led flexible services, and improved and safe 'flow' between providers. This has the potential to reduce length of stay, readmissions, and potentially reduced overall longer term health and care costs for the system. Whilst it is clear that these outcomes are positive in terms of clinical quality and patient experience, it is more difficult to quantify this impact in financial terms because individual treatment inputs can vary so significantly.

6b. Stroke Services and Neurology – Dependencies, Enablers, and Risks to Delivery

The ambitions for stroke will be affected by the following dependences:

- ***Sustained commitment and engagement from all stakeholders involved in the stroke pathway*** – Stakeholders and collaborating partners include Frimley Health and Care ICB/ICS leads; Frimley Health NHS Foundation Trust (including Frimley Park Hospital, Wexham Park Hospital and Farnham Hospital); Berkshire Healthcare NHS Foundation Trust; five Place based partnerships of Bracknell Forest, Windsor and Maidenhead, Slough, Surrey Heath, North East Hampshire and Farnham; Primary Care Network and teams; HCRG Care Group; Clinical Leads across Stroke Rehabilitation Teams; Frimley / Surrey Heartlands ISDN Stroke Survivor and Carer Panel; Stroke Association; Headway; Healthwatch; Surrey County Council; Surrey and Borders Partnership; other voluntary and third sector organisations and facilities such as sports centres. There is a risk that without consistent engagement from all providers/organisations within the ISDN, developments and improvements across the stroke pathway and the ability to meet the ambitions of the National Stroke Service Model will be delayed. Engagement across the Stroke pathway is continuing to improve and is supported by ISDN initiatives such as the Acute Stroke Centre ISDN 'Roadshow' visits. The ISDN team will also continue to review the governance structure to support further improved engagement

- ***Workforce*** - There are significant workforce shortages affecting the stroke pathway. The risk is that workforce shortages will impact on engagement, service delivery, service transformation, and sustainability. The ISDN is continually reviewing this risk and escalating concerns through the ICS as appropriate. In addition, the ISDN will link in with ICS workforce leads and integrate learning from colleagues from across the region to develop innovative workforce solutions

- ***Complex and multiple commissioning arrangements relating to community rehabilitation*** - have the potential to impact on the implementation of the Integrated Community Stroke Service Model. The SQuIRe catalyst project is intended to support the ICS to address this risk by embracing the new architecture of the NHS and system working with ICSs/ICBs leading on local quality improvements to deliver sustained transformation

- ***Funding*** – some of the service developments e.g., the pre-hospital video-triage pathway will require ongoing funding to be sustainable. In the case of the latter pathway, it is expected that the project evaluation will demonstrate the positive impacts of the pathway and this will be used to develop a business case to secure long-term funding for the Band 6 'Stroke Triage Nurse' role. This is so it becomes embedded into the stroke service model within the Trust and sustainable provision of the pathway will be achieved.

- ***Digital / IT*** - The introduction of EPIC continues to have a significant impact on clinical teams and clinical time which is impacting on SSNAP data accuracy and performance. Equally, developments such as the Thames Valley and Surrey Local Health and Care Record Programme and the introduction of EPIC have the potential to support and enable improved efficiencies and improved insight and analysis of the stroke pathway. Robust and prompt digital support is required to enable these efficiencies and advantages to be realised.

6c. Cardiovascular Disease – Strategic Context

The long-term sustainability of our health and social care system depends on people living longer in good health. Our Frimley ICS strategy 'Creating Healthier Communities' has a focus on reducing health inequalities and our aim is to identify and target the cohorts of people where physical and mental health problems can be prevented or outcomes improved. It has a focus on deprivation, inequalities, and those with most complex needs. The ICS Strategy shares its six Strategic Ambitions with the LTP, which will deliver fundamental change and improvement to the health and wellbeing of the people who live and work in our communities. Our agreed priorities at local level align strongly with the overall strategic ambitions and their delivery with, and close to, local populations and communities.

The ICS Living Well Strategic Ambition demonstrates our collective commitment to taking greater action on prevention and health inequalities (see Figure 1).

Analysis shows we have stark intra-area health inequalities, with poor, and worsening, health and wellbeing outcomes in our more deprived communities and other groups. Cardio-vascular, respiratory, COPD, hypertension, diabetes, obesity, mental health and alcohol abuse are all population health issues presenting challenges across the system, with differing levels of prevalence, and determinants, between Places. The deprivation gap for life expectancy is being driven by preventable and manageable diseases. We want to help address the root causes of lifestyle behaviours (by reducing modifiable risk factors - obesity, alcohol and tobacco consumption), and work together, to provide personalised support to tackle them. Co-creation 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 to preventing it and help create the right conditions to support residents and patients to live longer in good health. The challenges presented by the pandemic have also meant that existing health inequalities have been compounded and, when we look at those who have been most at risk of poor outcomes, it is often those with long term conditions or health behaviours that are amenable to change. The Living Well Ambition therefore supports our general aims around helping develop strong, resilient and healthy communities.

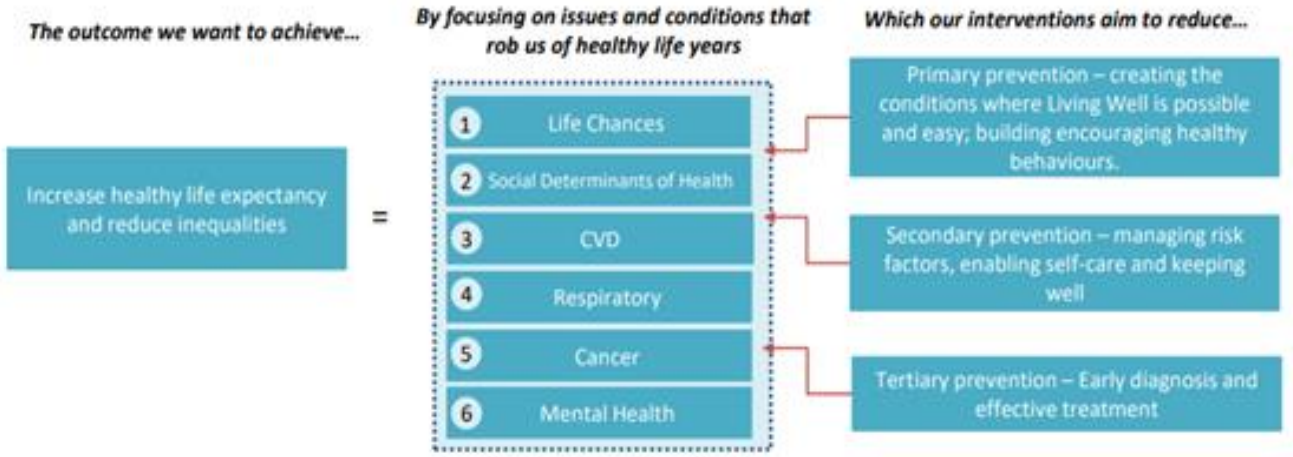


Figure 1.
We know that the key conditions that account for the differences in life expectancy between our more and less deprived communities (i.e., cardiovascular disease, cancer, and respiratory disease) and those that take our years of good health from us (mental ill health) are amenable to prevention. Using population health management to identify cohorts in our population at particular risk will enable us to target our interventions.

6c. Cardiovascular Disease – Strategic Context

The importance of CVD has been further highlighted during the course of the pandemic, with CVD related outcomes driving the demonstrated inequalities in Covid-19 outcomes attributable to hypertension, diabetes, and chronic kidney disease. During the pandemic fewer people came forward for non-urgent/routine care where the early signs of CVD are often picked up. As a result, we saw a reduction in diagnosis, monitoring and treatment of the A-B-C conditions. Overall the ICB performs worse on hypertension management to target (all ages) than England as a whole, therefore, there are improvement opportunities. In addition, social distancing measures such as lockdown may have had a negative impact on the cardiovascular health of the population. Limited social interactions has the potential to increase the risk of CVD itself, as social isolation and loneliness are significant risk factors for CVD. During lockdown, people had an increased likelihood of depression, poor diet, alcohol consumption, being sedentary, and increased blood pressure. Such effects are most pronounced in those from poorer socioeconomic backgrounds, who were more likely to lose jobs and less likely to have gardens in which to exercise. Covid-19 has created unmet need and increased health inequalities and we are gathering a range of insights to identify specific cohort groups across our communities where we need to take further action. This is work that is cutting across all areas of our plans.

The impact of covid has sadly affected all achievements against the PHE ambitions of 80% (set in 2019) of patients treated to target. For Frimley ICS, the percentage of hypertension patients managed to target fell from 69.7% in 2019/2020 to 47.8% in 2020/2021. In real terms, this means that there are an estimated 23,350 extra patients that need to be managed to target to meet the PHE ambition. The increase in patients not being managed to target could have a significant clinical impact if not addressed. Modelling indicates that this reduction in blood pressure control could lead to an estimated additional 147 heart attacks and 220 strokes occurring over a three year period. CVD is one of the conditions most strongly associated with health inequalities and in Frimley ICS, circulatory diseases (defined as heart disease and stroke) are the greatest contributor to the gap in life expectancy between the most and least deprived areas. Prevalence is higher and onset earlier in those living in more deprived areas and there are inequalities in hypertension management which negatively impact males, people aged 18-39 and 40-59, and people with Black, Missing and Mixed ethnicities. Using our system shared care record enables us to proactively manage patients and target interventions where we see the greatest inequalities. Data also tells us it is multimorbidity driving demand and cost.

The NHS Health Check programme has also been impacted during covid. Its main function is primary prevention, behaviour change, smoking, physical inactivity, and excess alcohol consumption, which can contribute to reducing inequalities as highlighted by CORE20PLUS5 and CVD Prevent. It has a role in secondary prevention too, so restoring the number of checks delivered to pre-pandemic levels is critical. NHS Health Checks can identify risk factors for early death and disability from CVD. The programme aims to prevent CVD and associated conditions, through early assessment, awareness, and management of risk factors. Cardiovascular diseases are preventable with action most impactful within communities that carry a disproportionate burden of disease, therefore, the NHS Health Check provides an opportunity to address entrenched health inequalities. It can supplement diagnoses made from routine clinical practice and targeted interventions, such as remote monitoring.

The long-term impacts of the pandemic will continue to be felt whilst new challenges are emerging, such as extreme weather events and the cost of living crisis. Cold weather increases the risk of heart attacks and strokes and some groups are particularly vulnerable to the effects of cold weather. We know that rates of conditions such as heart failure are likely to become worse over winter due to increased fuel poverty. These conditions result in higher numbers of hospital admissions over winter and, therefore, should be a priority area.

In these uncertain times, it is imperative that we work collaboratively to improve their preparedness and responses to different contingencies. The case for change in this area is compelling – in that we have a higher number of people presenting with strokes and MI than pre-pandemic, against a mortality of covid already impacting on families and communities. CVD is the single biggest area where the NHS can save lives over the next 10 years and there is a need to focus efforts for recovery and improvement on those practices that have seen a sharp drop in blood pressure management. However, we need to go further than simply going back to pre-covid levels, and target population groups before the pandemic with historically low uptake. Likely disruption to routine prevention services during the pandemic, in part, is contributing to the current excess mortality we are seeing, therefore, there is an urgent need to identify and treat individuals who have missed treatment for CVD risk factors.

Measuring blood pressure could be done in many settings, for example in the community and workplaces where people go as part of their daily lives, making it more convenient for individuals to come forward for assessment. Community Pharmacies are uniquely placed to support the detection and ensuing treatment of hypertension and CVD, which will reduce the burden on General Practice and reaching people who are often not well supported by existing services and experience health inequalities. The pandemic has highlighted the essential role that faith/community leaders play in the health of local communities. They have unparalleled reach into communities, therefore, the increasing pressure on the NHS makes it clear we need to work differently to sustain our health service for the future.

As part of the ICS aim of increasing healthy life expectancy and reducing health inequalities, the Living Well Ambition looks to embed prevention and treatment of risk factors and diseases that reduce the years we live in good health. CVD is one of our most common causes of death and the most common cause of adult disability. We want to build healthier communities with reduced inequalities by taking a system wide approach to reducing CVD risk factors and implementing evidence based clinical interventions to reduce the incidence and progression of CVD. This will contribute to the NHS Long Term Plan to help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years.

6c. Cardiovascular Disease – Progress Since the Long Term Plan

With an ambition to prevent CVD and up to 300 strokes and 230 heart attacks per year, each of our five Places is developing a tailored partnership plan to tackle hypertension. 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 since Summer 2022.

CVD Prevention

- CVD Prevention Group established - Places are developing a tailored partnership plan to tackle hypertension initially (with links to NHS Health Checks and other modifiable risk factors)
- Building on our campaign work; targeting engagement with groups at higher risk (May Measurement month, Hypertension Day, Know Your Numbers, Smoking)
- Throughout the Summer of 2022 a Blood Pressure Bus visited various sites across the ICS and offered testing in the local community – checks included: pulse, BMI, and smoking, applying 'Make Every Contact Count' principles. The bus visited 16 locations across Frimley and reached over 1200 people.
- Aligning to Core20PLUS5, to accelerate and augment implementation of the approach
- Making progress against NHS LTP high impact actions for stroke and cardiac care
- Rolling-out the Community Pharmacy Hypertension Case Finding Service
- Working closely with Community Pharmacies, vaccination sites, and the wider Primary Care Team to help us engage and interact with our residents and workforce in different ways
- Identifying patients potentially at risk and offering the use of BP monitors, piloting a system where remote BP readings are entered directly into the patient's clinical record
- We are exploring a number of digital solutions to support practices, with two PCNs are piloting Omron hypertension plus – which allows for remote BP readings to be entered directly into the clinical record. This will help with medium term behaviour change and blood pressure control.
- Practices are taking an AccurX Florey approach which has been highly successful in Surrey Heath and Slough
- Education to ICS nurses to encourage opportunistic BP checks; 'making every contact count'
- Funded additional BP Machines which are being provided to residents in our deprived/underserved communities
- NHSC recovery plans in place to catch up on NHSHC
- Hypertension and Whole Systems Approach to Obesity (WSATO) workshops delivered
- Videos, leaflets, posters, and communications toolkit developed for hypertension

Modifiable Risk Factors

Embedded the NHS Digital Weight Management Programme. Our ICS has the greatest uptake across the country.

- Whole Systems Approach to Obesity workshops delivered to tackle drivers of obesity and ICS Healthy Weights group established.
- 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) working closely with our Community Stop Smoking Services
- Alcohol hospital specialist service and brief interventions
- Community Asset Based Approaches in Local Authority to support communities
- Healthy Conversations - Making Every Contact Count

6c. Cardiovascular Disease – Our Five Year Priorities

Priorities for 2023-2028 are as follows:

- Improving and increasing early detection and treatment of CVD and work towards people routinely knowing their 'ABC' numbers
- Focussing on health inequalities to improve and reduce variation in health outcomes across disease areas in our system
- Support health improvement behaviour change programmes across the ICS
- Support community engagement with groups with poorer health and wellbeing outcomes, to understand barriers and co-produce solutions
- Roll out Tobacco Dependency programme, to ensure the provision of a resilient, sustainable programme that supports more people accessing secondary care to quit smoking
- Renewed commitment to smoke free sites across our services
- Continue to use the Social Prescribing function to support vulnerable people, linking with community hubs to support long waiting lists
- Using Healthy Conversations (MECC) as an enabler to addressing inequalities
- Develop a place partnership plan to include actions on the living well priorities most applicable for their populations
- Continue to work with the ISDN to ensure services are coherent and effective
- Develop our capability to co-produce solutions to the wider determinants that cause poor lifestyle behaviours
- Develop a Frimley ICS Healthy Weights action plan; a coordinated approach to delivering the WSATO across our five places, by enhancing existing places plans
- Optimisation of heart failure treatment through annual reviews
- Cardiac rehabilitation for patients post ACS and diagnosis of heart failure and optimising management post ACS, including lipid management
- Develop a communications strategy to explain the benefits of statin to the public
- Roll out our updated lipid management pathway, including rolling out training sessions to local prescribers to support its implementation. To further support this priority, we will employ a team to focus on improving lipid management across Frimley ICS. This will focus on secondary prevention, but we will take the opportunity to promote uptake of statins in primary prevention too
- We will continue to promote NHS Health Checks which will improve identification of people who have a high QRISK score, as well as spotting early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia.
- Continue to roll out the Community Pharmacy hypertension Case Finding Service
- Supporting PCNs to find and treat people with high BP and offer treatment in a timely way and ensure delivery of CVD prevention using Network DES
- Facilitate the spread of good practice and innovation; explore developing a resource repository, and/or other ideas emerging from the ICS CVD Prevention and place meetings
- Further develop our range of resident resources to promote good self-management, health literacy around BP and encourage control, e.g., leaflets, easy reads, translated materials, videos, trusted information websites, repository for guidance and toolkits for system partners, to best promote wide community access to BP information and education
- Explore staff offers of support around smoking, healthy weight and hypertension

- **Ensure addressing prevention and inequalities is everyone's business**

6c. Cardiovascular Disease – Our Priorities for 2023/24

Over the next 12 months our priorities are as follows:

- Focus on primary prevention and management of hypertension
- Increase the detection and management of people who have undiagnosed hypertension
- Increase access to BP testing in wider community settings
- Work with practices and PH to maximise NHS Health Checks uptake, and follow up to support early diagnosis and management
- Increase support for patient self management and self testing to become routine practice
- Ensure delivery of CVD prevention DES
- Accelerating MECC interventions; action through routine outpatient appointments, antenatal care, and perioperative assessments, noting that secondary prevention of CVD and should be seen as everyone's responsibility
- Working closely with Community Pharmacies and supporting uptake of BP detection
- Scope and start to develop Frimley ICS CVD Prevention Strategy and action plan
- Workplace Health; explore staff offers of support around smoking, healthy weight, and hypertension
- Health improvement campaigns across the ICS; raising awareness of CVD risk factors and opportunistic detection, and develop a 12-month communications plan
- Contributing and aligning to the CORE20PLUS5 approach
- Using Connected Care data to develop specific measures to address suboptimal management of hypertension
- Articulate opportunities of partnership and develop a tailored partnership plan to tackle hypertension in each of our five Places, ensuring interventions embrace ethnic and cultural diversity and target communities experiencing poorer outcomes
- Support individuals at risk of CVD to make behaviour changes: becoming more active, maintaining a healthy weight, safe levels of drinking, and stopping smoking
- Develop a Frimley ICS Healthy Weights action plan
- Roll out Tobacco Dependency programme in the Acute and Maternity
- Roll out our updated lipid management pathway
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Benefits and Outcomes

- Strengthening the ability of the NHS to deliver prevention activities, e.g., workplace health, the influence of Anchor Institutions
- Physical activity as part of treatment regimens
- Increased evidence-based decision making to improve health and act on inequalities
- Promoting self-care and taking responsibility for your own health for those who are able
- Reduction of coronary heart disease, stroke, and heart failure
- Better support for underserved and vulnerable groups to improve their health and improve equity
- Aligned delivery with LTP and CORE20PLUS5
- Contribute to increasing healthy life expectancy and reducing the gap in healthy life expectancy between our least and most deprived communities
- Improved detection and management of CVD risk factors
- Contribute to the prevention of other non-communicable diseases
- Increase the detection and management of people who have undiagnosed hypertension
- Increase awareness and access to blood pressure testing in wider community settings
- Improved staff health and wellbeing
- Strengthen joint working between local partners
- Cost avoidance and productivity gains

6c. Cardiovascular Disease – Our Leadership Approach

Our system leadership approach to hypertension aims to embed a widespread culture of integrated cross-sector working, in which responsibility for action is distributed beyond just health partners. Local leadership has been integral in making a difference to how hypertension and its causes are tackled. The ICS Living Well Ambition has inspired a wider range of partners to join this collective action and to consider how they can collaborate to tackle high blood pressure within their area of scope. It's important to recognise that the new additional roles being recruited to in Primary care (Clinical Pharmacists, Social Prescribers, Care Coordinators, and Health and Wellbeing Coaches) have an important role to play in delivering high quality healthcare to prevent CVD. Health and wellbeing coaches can produce positive effects on the adoption of healthy behaviours, freeing up clinical capacity and improving patient outcomes.

Establishing an overarching CVD prevention group and further regular conversations at Place and within PCNs, helps to ensure continued support and collective action at all levels. Clinical and non-clinical input has been integral to enable us to work towards making a significant impact in driving CVD recovery in our system. A collaboration made possible through diverse leadership; multiple layers of distributed leadership between clinical, professional, and administrative staff at all levels. Quality improvement has been embedded within the programme, which is underpinned by routine use of data from Connected Care to support development of the programme and improve delivery and outcomes.

All partners in Frimley ICS, alongside voluntary and community organisations, have been engaged in supporting this partnership approach to working. Contact has been made directly and through workshop opportunities.

Our focus for a partnership approach:

- Highlight why CVD is such an important issue for Frimley and reinforce as a key priority
- Show an evidenced link to our ambitions to reduce health inequalities and create healthier communities
- Provide a platform to share work and best practice from both within Frimley and beyond

Our focus for local people:

- Highlight the risks associated with hypertension
- Provide easy to understand information in a variety of formats
- Offer different opportunities to have a BP reading taken and provide guidance on how people can do this at home
- Educate people in the importance of knowing their numbers (e.g., BP, heart rate)
- Educate and empower people to make lifestyle changes that can reduce high blood pressure

The work of the partnership to systematically identify specific population health improvements, most particularly with regard to hypertension, 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.

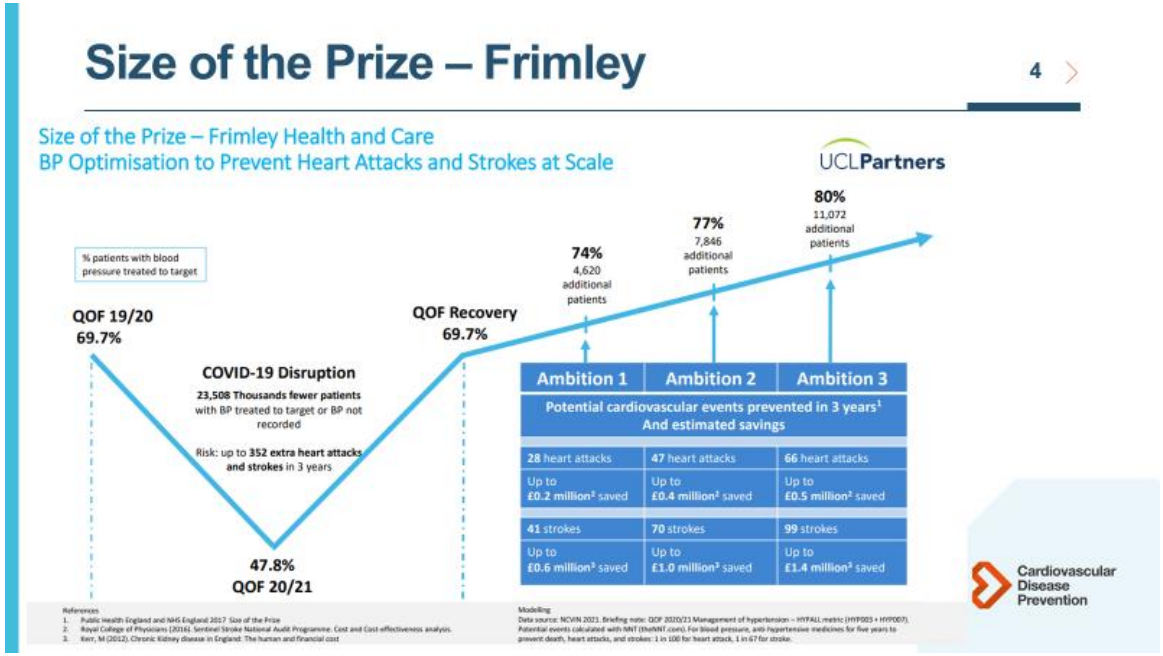
NHS Health Checks can identify risk factors for early death and disability from CVD. The programme aims to prevent CVD and associated conditions through early assessment, awareness, and management of risk factors. Cardiovascular diseases are preventable with action, most impactful within communities that carry a disproportionate burden of disease. Therefore, the NHS Health Check provides an opportunity to address entrenched health inequalities.

The rising cost of living makes it more challenging for people to meet basic needs such as food, clothing, housing, transportation, and prescription charges. Making changes to healthy behaviours is more challenging when people are concerned about basic needs. Financial barriers to accessing medications and enough food, let alone healthy, nutritious, food can have a catastrophic effect on health and wellbeing outcomes and increased use and cost of other health services. Food poverty and food insecurity is also rising, putting further barriers in the way to maintain a healthy weight. Obesity is a major risk factor for CVD, diabetes, and cancer and levels are rising. Time poverty is also on the rise because people are working multiple jobs, making it difficult for them to attend appointments.

6c. Cardiovascular Disease – Dependencies, Enablers, and Risks to Delivery

There are large cost savings and health benefits to our system if individuals with a high risk of CVD could be detected and managed to age-appropriate targets, as outlined in NICE guidelines. Detecting undiagnosed hypertension early is likely to produce the greatest benefits and better prognosis for individuals than those diagnosed later, which is likely to cost the system more in treatments, as well as serious complications arising that would require more expensive treatments and impact the patient's quality of life. PHE's modelling suggests that over 10 years the societal return on investment is estimated to be £2.30 for every £1 spent, including the value placed on improved health. CVD morbidity is also a major issue for health and social care as 6.8 million people are living with cardiovascular conditions. This places a considerable financial burden on the NHS and wider society, with CVD-related healthcare costs alone in England amounting to an estimated £7.4 billion per year, and annual costs to the wider economy being an estimated £15.8 billion.

The estimated number of patients needed to be treated to target to reach the PHE 80% target has significantly increased between 2019 and 2021. For Frimley ICS, the gap to the ambition has grown by 23,350 patients – which means the estimated costs of additional heart attacks caused is £1,096,000 and the estimated cost of additional strokes caused is £3,062,000 (figures rounded to the nearest £1,000 – data taken from OHID modelling).



Health is about more than healthcare alone, and that to be implemented effectively, we must work in partnership with residents, local government, and wider stakeholders to reduce health inequalities, through addressing the wider social determinants of health. To make a difference on CVD and 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 underserved 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, consequently, bringing that learning back in a timely way to enable further change in an agile way. In order to truly revolutionise the way CVD is prevented requires cross-sector collaboration and integration of services and all partners in Frimley ICS. Voluntary and community organisations, need to be engaged in supporting this partnership approach to tackling CVD.

While preventing and treating obesity, smoking, alcohol and hypertension, requires financial investment, the cost of failing to prevent and treat these risk factors will be far higher. The cost of inaction will be unequivocally greater, therefore, preventing ill health is key to how we reduce pressure on the health system.

6d. Diabetes – Strategic Context

In 2022, there are approximately 4,000 residents living with type 1 diabetes, and 40,000 residents diagnosed with type 2 diabetes. By 2030, Frimley ICS will have 72,000 residents with diabetes; the majority (90%) being diagnosed with type 2. People with diabetes are 2.5 times more likely to have a heart attack and twice as likely to have a stroke, than the general population. Furthermore, the mental health impact is significant, with prevalence of depression twice as high in those with diabetes than the general population. We estimate that at any one time, 25% of our admitted patients in acute hospitals have diabetes and their average length of stay is 10.3 days.

People from deprived areas or an ethnic minority are more likely to have diabetes. Analysis of Connected Care data shows us that diabetes is **the** leading cause of inequalities in our system.

Age-sex standardised prevalence of conditions by deprivation quintile and ethnicity

Colour represents statistical significance: Significantly Higher | Similar | Significantly Lower

	Variation by DEPRIVATION QUINTILE (1= 20% most deprived areas)					Variation by ETHNICITY				
RegisterDescription	1	2	3	4	5	Asian or A...	Black or B...	Mixed	Other Et...	White
Asthma	5.6%	5.5%	5.5%	5.1%	5.1%	5.4%	4.3%	5.3%	3.1%	5.7%
Atrial fibrillation	2.1%	2.0%	2.1%	2.3%	2.2%	1.2%	1.2%	1.7%	1.8%	2.4%
BMI >= 35	8.3%	7.4%	7.4%	6.3%	4.5%	4.4%	8.3%	5.6%	3.8%	6.4%
Cancer	2.9%	3.0%	3.3%	3.6%	3.9%	2.1%	3.4%	2.9%	3.2%	3.9%
CHD	4.2%	4.0%	3.4%	3.0%	2.5%	4.8%	2.4%	3.2%	2.5%	2.8%
CKD	4.7%	4.0%	3.7%	3.3%	2.7%	3.3%	5.8%	3.6%	2.1%	3.2%
COPD	2.6%	2.1%	1.9%	1.5%	0.9%	0.7%	0.5%	0.8%	0.9%	1.5%
Current Smokers	15.3%	13.9%	13.4%	10.9%	7.8%	6.1%	7.1%	9.2%	9.6%	12.0%
Dementia	0.9%	0.9%	0.8%	0.8%	0.8%	0.6%	1.1%	0.8%	0.8%	0.8%
Depression	11.1%	10.0%	11.6%	10.4%	9.6%	5.3%	6.4%	8.4%	6.1%	12.2%
Diabetes	11.8%	10.5%	7.8%	6.3%	4.4%	14.3%	11.2%	10.0%	6.1%	5.0%
Epilepsy	0.7%	0.6%	0.6%	0.6%	0.5%	0.3%	0.3%	0.4%	0.3%	0.6%
Heart failure	1.6%	1.4%	1.2%	1.0%	0.8%	1.2%	1.0%	1.0%	0.7%	1.0%
Heart Failure Lvsd	0.7%	0.5%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.2%	0.4%
Hypertension	18.4%	17.7%	16.1%	14.6%	12.7%	18.8%	21.2%	17.0%	12.8%	14.0%
Learning disability	0.7%	0.6%	0.5%	0.4%	0.3%	0.4%	0.4%	0.4%	0.3%	0.4%
Medium/High Alcohol consumption	3.9%	4.1%	6.1%	7.6%	9.5%	2.1%	2.2%	3.8%	5.6%	9.3%
Mental health	1.4%	1.3%	1.0%	0.8%	0.6%	0.8%	1.5%	1.0%	0.6%	0.8%
Mental health Lithium	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
Non-Diabetic Hyperglycaemia	8.0%	7.1%	5.5%	5.0%	4.2%	9.0%	8.1%	6.5%	5.1%	4.3%
Obesity	11.0%	10.1%	9.4%	8.3%	6.1%	8.1%	11.2%	8.4%	5.6%	8.0%
PAD	0.7%	0.7%	0.6%	0.5%	0.3%	0.4%	0.4%	0.6%	0.4%	0.5%
Palliative Care	0.7%	0.6%	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%
Rheumatoid arthritis	0.6%	0.7%	0.6%	0.6%	0.5%	0.8%	0.4%	0.6%	0.4%	0.6%
Stroke/TIA	2.1%	2.0%	1.8%	1.7%	1.4%	1.7%	2.2%	1.4%	1.5%	1.6%

Figure 1. Connected Care Data on prevalence of conditions by deprivation decile and ethnicity (Q1, 2023).

6d. Diabetes – Progress Since the Long Term Plan

T2D prevention and early intervention:

NDPP - NHS Frimley has widely promoted the National Diabetes Prevention programme across the ICS footprint and has built up good engagement with primary care, allied health professionals, and residents. As a result the service is receiving approximately 500 referrals per month

Low Calorie Diet – Frimley ICS was one of the Wave 1 pilot sites for the Low Calorie Diet programme. Uptake into the programme has been slow, around 25 referrals per month. However, we have had some excellent success stories and a Frimley resident who achieved remission from diabetes recently spoke at the National Diabetes Professional Conference about his success with the programme.

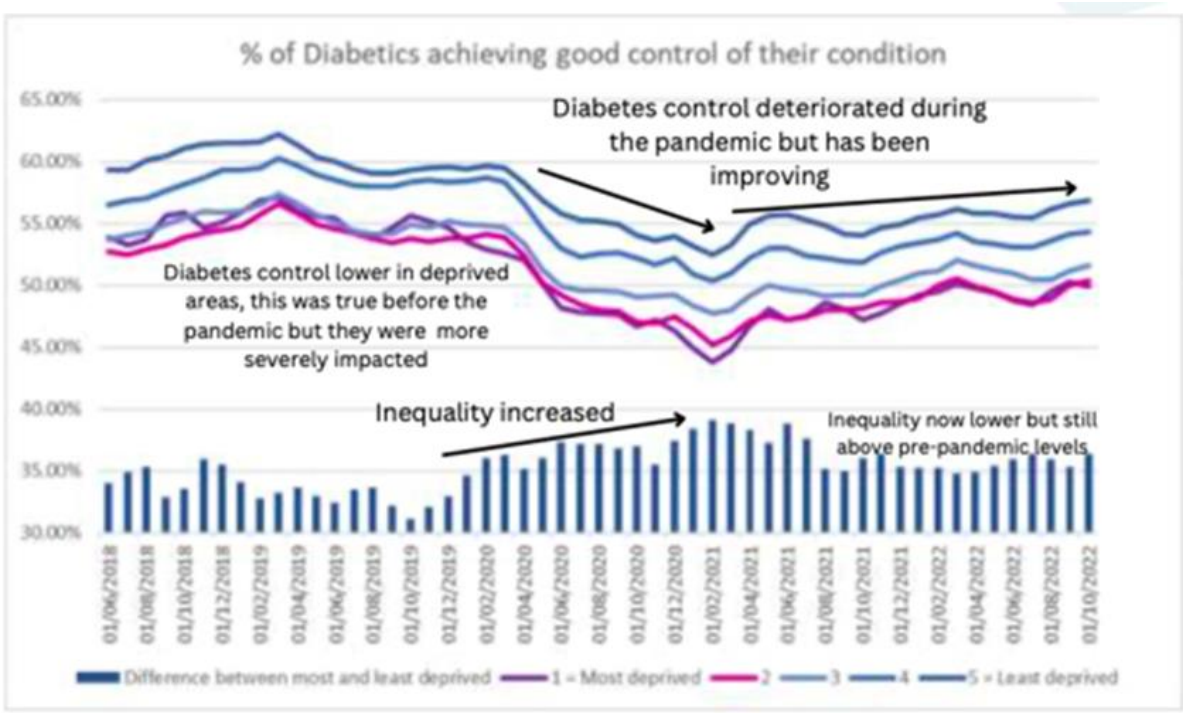
Structured Education – Uptake of structured education has been low, and Frimley ICS has encountered similar challenges to other areas in delivering a programme that has broad appeal.

Developing health professional teams:

The LTP confirmed investment in diabetes teams and a commitment to ensure MDT footcare teams and diabetes inpatient specialist nursing. This has been a challenge, especially with issues of recruitment, retention, and career progression.

Optimum treatment and care:

- In Frimley, approximately 70% of residents living with type 1 diabetes have been prescribed continuous glucose monitors
- Control of diabetes deteriorated the most in the CORE20 population 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 remains below pre-pandemic levels.



6d. Diabetes – Our Five Year Priorities

PREVENTION AND INEQUALITIES

- Current projection estimates show that by 2030, there will be approximately 24,500 additional residents with type 2 diabetes which will place a considerable burden on the system. By reducing the number of people who are overweight or obese, we can reduce the number of people developing the condition and the complications associated with it. Over the next 5 years the diabetes workstream will engage with system partners to support and deliver prevention initiatives, with a focus on tackling the inequalities associated with the condition

RESIDENT VOICE AND PEER SUPPORT

- Over the next 5 years, the diabetes programme will develop a model of working to involve residents in planning and co-production of services. The NHS LTP highlights the need for personalised care approaches to become embedded within the NHS and peer support is a valuable resource to support shared-decision making and self management.

STRUCTURED EDUCATION

- Over the next 5 years we will work to improve the structured education offer; working with healthcare professionals and communities to increase uptake

IMPLEMENTING NICE

- Diabetes care is evolving at a rapid pace; blood glucose monitoring technology and developments in pharmacotherapy are expected over the next 5 years. Implementing these changes will require joint working with residents, healthcare professionals, and system stakeholders, for considered decision making with a focus on improving outcomes and reducing inequalities

REDUCING ADMISSIONS AND LENGTH OF STAY

- Length of stay for patients admitted for surgery with diabetes is on average 3 days longer than those without diabetes, with the average length of stay for inpatients with type 2 diabetes at 10.3 days. Reducing admissions and improving inpatient care for people with diabetes will be a focus, using a variety of approaches and working with partners across the system

IMPROVING PODIATRY PATHWAY

- Diabetic foot problems are a common complication of diabetes, and people with diabetes are 15 times more at risk of an amputation than those without diabetes. Most amputations are preceded by foot ulcers. Ulcers and amputations have significant impact on people's lives and independence. This can result in prolonged hospitalisation and rehabilitation as well as increased demand on social care. Education and upskilling on diabetic foot issues as well as addressing issues in capacity, recruitment, and retention of podiatry teams will deliver improvements over the next 5 years

SUPPORT PRIMARY CARE

- The impact of covid-19 led to a significant decrease in the delivery and achievement of treatment targets in the eight care process for people with diabetes, as per NICE guidelines, in 2020/21 when compared with 2019/20. Using improved access to data, primary care will be supported to proactively identify patients who require medication reviews or care processes completed and highlight those who might benefit from remote monitoring

6d. Diabetes – Our Priorities for 2023/24

First year of diagnosis
- Focus efforts on getting it right for people in their first year of diagnosis and enable early access to services

High need groups
- Identify people with diabetes who have high service needs and work proactively to intervene early

National Diabetes Prevention Programme
- Improve engagement with South Asian residents and ensure we target areas of deprivation

Type 2 diabetes remission
- Transition to the new provider in May and establish relationships with stakeholders and build referrals

Peer support and resident voice
- Scoping exercise to establish best models for co-production and supporting self-management

Structured education
- Increase uptake by streamlining the offer across Surrey Heath and North East Hampshire and Farnham

Implementing NICE
- Implementing statutory appraisals from NICE, and guidance updates ensuring that clinical teams are supported to deliver

Medicines optimisation
- Proactively identify patients suitable for medicines optimisation and work with primary care to support

Podiatry
- Improve uptake of FRAME training and work with system partners to address issues of capacity and antibiotic prescribing

Remote monitoring
- Proactively identify patients who would benefit from additional support to manage their diabetes

Reducing length of stay in hospital
- Inpatient diabetes specialist nursing teams to support in acute and community settings, to improve perioperative care and reduce insulin errors during inpatient stays

Pregnancy
- Improve awareness and access to weight management and diabetes lifestyle support, with a focus on women living in areas of deprivation

Communications
- Between primary, community, and specialist teams to enable joint working and promote system working

6e. Respiratory – Strategic Context

The Impact of Covid-19:

The key challenges for our system have been the impact of covid on respiratory care. We have seen a decrease in diagnostics in terms of spirometry, and we have seen a decrease in patient reviews for patients with long term conditions.

This has meant we are now in a situation whereby people were added to disease registers without the diagnostics to confirm. This will have led in some cases to mis-management and inappropriate prescribing of medications.

We have also seen a reduction in usual rates of care, meaning the patients with known disease such as COPD or asthma are not always optimised.*

We have seen increased referrals to secondary care and longer wait times for pulmonary rehabilitation (PR). This means that patients needing PR are waiting longer than they should, and likely this has caused an increase in admissions for those conditions.*

Also during covid, maintenance classes were suspended and haven't restarted. Therefore, patients may be less fit than they were before, and less able to manage exacerbations of their conditions, leading to more ill health.

The introduction of referral to PR in QOF has led to increased referrals; further increasing demand on over stretched services. The 3-5 year national PR plan, to increase the PR offer by 50% and include other respiratory disease beyond COPD, is a challenge in terms of funding and recruitment.

On top of these challenges is recruitment. We are seeing increased numbers of staff leaving from nursing and physiotherapy roles within the teams, and there is a reduction of training places offered and also accepted.

Over the next 5 years we will need to create more flexible roles, better use of apprenticeship opportunities, and grow the value of band 4 roles.

* Data taken from Connected Care, 2019-2023.

6e. Respiratory – Progress Since the Long Term Plan

Medicines Optimisation

90% of NHS spending on asthma is on medicines, but the incorrect use of medication can also contribute to poorer health outcomes, increased risk of exacerbations, or admission. As part of the practice incentive scheme a number of practices have focused on identifying and managing patients on an inhaler with no respiratory diagnosis and some have worked on identifying practices and reviewing patients with a high usage of salbutamol. Progress on this will be measured at the year end.

Pulmonary Rehabilitation

We have been able to return to pre-covid conditions for PR, therefore, class size restrictions have been lifted. One of the teams has been able to become accredited, with the other team are aiming to submit by the year end. We have introduced new ways of working through virtual consultations and the provision of virtual and home PR. To reduce inequalities and improve access to PR, we have developed a set of video educational programs. We have also opened more clinics and pulmonary rehabilitation venues across the ICB patch to improve patients' access.

COPD

We have been able to restart spirometry activity in primary care and in addition have trained 134 staff across our system to undertake testing and interpret results. While this was initially restricted to the covid backlog of investigations we will, from next year, have an LCS to allow for spirometry and FeNO testing as required. This will reduce the need to refer to secondary care.

We have also supported practices to undertake COPD reviews and worked jointly with Interface Clinical Services to deliver this work. 41% of our practices have now had this support and in addition, further practices were supported in a similar way by GSK. We have facilitated practices to purchase FeNO testing and offered training for this. The new NICE guidelines will recommend a more widespread use of FeNO testing in primary care to better diagnose and manage asthma.

Engagement and Communications with Communities

We have also supported messages over winter to support vulnerable patients, including working with Asian Star Radio and Gurkha Radio to offer advice in multiple languages and reach populations who do not always come forward to receive health care.

We have had a media campaign to encourage key messages such as keeping warm, handwashing, mask wearing, and correct inhaler techniques, Next, we are hosting a Teams meeting to reach out to the community of patients waiting for pulmonary rehabilitation.

We have developed and implemented the Living Well with COPD program in collaboration with Talk Plus Services.

We have introduced the Support Clinics for Practices to help managing complex COPD and Asthma patients.

Regular MDT meetings for complex patients with the participation of palliative care team, hospital Specialist Nurses, Community Matrons and HF specialist nurses

We offer asthma follow up clinics within 4 weeks of ED attendance or admission, alongside clinic appointments for difficult to manage asthma and the delivery of biologics. We have specialist ILD clinics and work closely with the tertiary centre to manage those on antifibrotics and specialist medication. We offer specialist COPD clinics for complex management and assessment for surgical treatments alongside diagnostic clinics for those with respiratory symptoms without formal diagnosis. We also offer specialist physiotherapy clinics for dysfunctional breathing pattern disorders.

6e. Respiratory – Our Priorities

Our Five Year Priorities

- Decreased levels of smoking across the ICB with funding, and consistent stop smoking services that people can access easily
- Increased roll out of lung health checks identifying earlier lung cancers, as we have already seen from our Slough pilot. To include spirometry in the total lung health checks and ensure there are robust pathways for incidental non cancer findings (from radiology an anticipated 10% will find ILD, 33% Bronchiectasis and 50% emphysema, alongside cardiology risk)
- Greater provision at PCN level of respiratory champions, supported by the training hub and the respiratory specialist teams
- Development of our CDCs with lung physiology and a breathlessness pathway delivered jointly with cardiology, leading to faster diagnosis. This aims for referral to diagnosis in 62 days initially, and ultimately 33 days, with less hand offs
- We want to see discussion of patients at PCN/place level, reducing the need for an onward referral; redesign of referral pathways to include accelerated access for severe asthma patients for consideration of biologics; faster referral of patients with suspected ILD; a pathway to allow greater access to antifibrotics (as per NICE guidance); and shared care of those on antifibrotics. We want to see accreditation of our pulmonary rehabilitation services across the ICB and to grow the teams so we can deliver a more responsive service with decreased waiting times
- Continuation of already started sessions for the Living Well with COPD Program, support clinics for complex respiratory patients, and regular MDTs, using specialist expertise to review complex, homebound, patients at home where necessary
- Development of transitional services for young people with respiratory needs, in particular those on home oxygen, cough assist, NIV, or asthma. This will require commissioning, including specialist physiotherapy.

Our Priorities for the Year Ahead

- As this Joint Forward Plan is developed, we will undertake a deep dive to look at our population health data for respiratory and our urgent care opportunities to help us identify how we can be more pro-active and support those areas with greater needs
- We will also hold a strategy session to look at what improvements we can make to our existing offers from our specialist teams
- We have already held teaching session across the ICB at the GP education events, and will continue to do this for 23/24, as well as looking at how practices in need can be better supported. We are aiming for more discussion of patients and less need to refer for an outpatient appointment
- We will role out an LCS for spirometry and FeNO to ensure all breathless patients receive timely and accurate diagnostics and any onward care they require
- Develop a formal referral system to enable community pharmacists to refer to primary care or other organisations as appropriate
- Develop consistent guideline for diagnosis and management of asthma including the referral pathway for severe asthma including biologics
- Develop a way to implement targeted case finding for people with symptoms suggestive of COPD, increasing our diagnosed COPD population which is below prevalence figures.
- We will also develop a breathlessness pathway to ensure patients do not bounce around the system, but receive an appropriate diagnosis in a timely fashion (62 days) delivered through our CDC hubs. We will manager this jointly with cardiology
- We must increase awareness of managing comorbidities in people with COPD, providing more holistic care with particular regard to cardiovascular and diabetic risks, developing a protocol for risk assessment and treatment

7. Planned Care – Strategic Context

Addressing Factors Contributing to Increasing Demand

As populations continue to grow, there has been a noticeable increase in demand for planned care services. Several factors contribute to this trend, including:

Population Growth
The growth in population has led to increased demand for healthcare services. This trend is particularly noticeable in urban areas where population growth is highest.

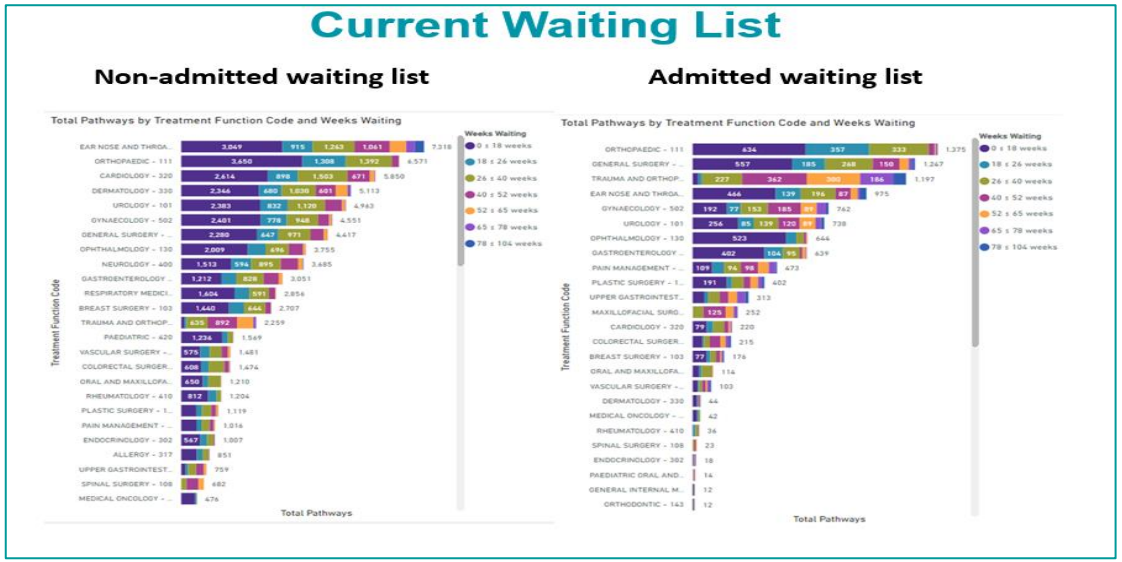
Ageing Population Resulting in Higher Disease Burden
An ageing population has resulted in a higher burden of disease, which has contributed to an increased demand for planned care services. The elderly population is more prone to chronic diseases such as diabetes and cardiovascular diseases, which require regular monitoring and treatment.

Increased Availability of Treatments
The availability of new and advanced treatments has resulted in increased demand for planned care services. As medical technology advances, more patients are seeking treatments that were previously unavailable or inaccessible.

Demand Related to Lifestyle Factors such as Obesity
Obesity has become a major health concern, resulting in increased demand for planned care services. Obesity is a contributing factor to many chronic diseases, and patients with obesity require specialized care.

Large Elective Backlog Resulting from the Pandemic: Reducing the Backlog to Meet NHS Targets
The pandemic has resulted in a large elective backlog that needs to be reduced in line with NHS targets. This includes outpatient care, diagnostics, and surgical treatments. The backlog has caused significant delays for patients, impacting their health outcomes and quality of life.

Reducing the backlog is a top priority for our system. This requires a collaborative effort from healthcare providers and staff to ensure that patients receive timely care. It is crucial to prioritize patients with the most urgent need and provide effective communication to manage expectations. By reducing the backlog, the NHS can ensure that patients receive the care they need, improve health outcomes, and meet national targets.



7. Planned Care – Our Delivery Focus Areas

Reducing Waiting Times for Care and Treatment
Reducing waiting times for care and treatment is a significant challenge in planned care. Longer waiting times can impact patients' health outcomes and quality of life. Addressing this challenge requires streamlining processes, increasing capacity, and prioritising patients based on their clinical needs.

Increasing Productivity to Above Pre-pandemic Levels
The pandemic has had a significant impact on healthcare services, leading to a decrease in productivity. Addressing this challenge requires increasing workforce capacity, improving workflow processes, and adopting innovative technologies to improve efficiency.

Maintaining Access in the Light of UEC Pressures
Maintaining access to planned care services while managing urgent and emergency care (UEC) pressures is a significant challenge. This requires effective communication, collaboration, and coordination between healthcare providers to ensure that patients receive the right care at the right time.

Reducing Health Inequalities in Relation to Planned Care Access and Waiting Times
Health inequalities in accessing planned care and waiting times are a significant challenge. Addressing this challenge requires a comprehensive approach, including targeted interventions for specific groups, improving access to services, and addressing the root causes of health inequalities.

Ensuring Sufficient Workforce Is Available to Address the Population Needs
Ensuring sufficient workforce is available to address the population needs is a significant challenge. This requires effective recruitment and retention strategies, training and development programs, and flexible working arrangements to meet the diverse needs of the workforce.

Reducing the Effect of Estates Issues Related to RAAC Planks
Reducing the effect of estates issues related to RAAC planks is a significant challenge arising from the loss of operating capacity from an estate that cannot be always be fully utilised.

Increasing Estates and Workforce Capacity for Diagnostics
Increasing estates and workforce capacity for diagnostics is crucial for addressing the growing demand for planned care services. This requires investment in infrastructure, equipment, and staff to improve access and reduce waiting times for diagnostics.

Utilising Digital Opportunities Effectively Whilst Ensuring No One Is Left Behind
Digital technologies offer opportunities to improve the delivery of planned care services. However, it is crucial to ensure that no one is left behind in the adoption of digital technologies. Addressing this challenge requires effective communication, training and development, and targeted interventions for specific groups.

Taking Advantage of New Treatments, Technology Developments, and AI
New treatments, technology developments, and AI offer opportunities to improve the quality of planned care services. Addressing this challenge requires investment in research and development, effective adoption strategies, and ensuring that new technologies are safe and effective for patients.

7. Planned Care – Our Priorities for 2023/24

Reducing demand	Increasing capacity	Change
• Referral management • Primary care practice support including buddy systems • Clinical guidance on DXS • Improving referral criteria utilisation • Triage • Advice and Guidance • GPWSI services • Evidence-based interventions programmes • Training and education • Workforce capacity delivery	• Heatherwood expansion • Wexham extended day • Waiting list initiatives • Insourcing • Outsourcing • Independent sector provision • Community Diagnostics Centres • Efficiency (particularly in radiology, endoscopy, outpatients, and theatres utilisation) • Consent • Patient communications • Tier 2 services	• Pathways (cardiac, ophthalmology, dermatology, pain, MSK, breast) • PIFU/discharge • Virtual OP • Improve elective day case procedures rate • One-stop diagnostics pathways • Pre-operative pathways • Waiting Well programme • New roles • High Volume Low Complexity/Superlists • MyFrimleyHealth (MFH) • My Planned Care • Innovation

23/24 Priorities

- Reduce avoidable referrals in dermatology, ENT, MSK, pain, gynaecology, cardiology
- Provide alternative services in cardiology, pain, ENT and MSK
- Roll out the MSK app and scope for pain
- Review current provision in Tier 2 services
- Increase capacity through additional diagnostics funding and Heatherwood Hospital elective hub
- Reduce workforce gaps through retention as well as training and recruitment
- Maximise IPS capacity
- Increase efficiency to above pre-pandemic levels
- Improve theatre utilisation and day case rates to meet national targets
- Increase PIFU and reduce follow up demand
- Maximise opportunities from the MFH app
- Improve readiness for surgery using population health information and remote monitoring
- Ensure inclusive recovery through rounds of waiting list analysis and actions

Benefits/Impact

- Care as close to home as possible using appropriate skills
- Effective use of scare workforce
- Patient self management and responsibility
- Leveraging resources within current funds to increase resource utilisation
- Improve staff experience and effectiveness at work
- Reduce wating list sizes and times
- Improved patient experience
- Reduce patient morbidity associated with long waits for treatment
- Reduce health equality gaps
- Leverage innovation opportunities
- Requires further work on cost/benefits, impact on population health and financial position

7. Planned Care – Our Five Year Priorities

Recover Waiting Time in Line with NHS 3 Year Elective Recovery Plan by March 2025
Recovering waiting times in line with the NHS 3 year elective recovery plan by March 2025 is one of our highest priorities as an NHS partnership.

Recover Waiting Times to Meet the NHS Constitutional Standards
Beyond this, and over the full five year period of this plan, we intend to meet the full range of NHS Constitutional Standards for these services.

Increase Diagnostic and Treatment Volumes to Meet Demand
To achieve this we will increase diagnostic and treatment volumes to meet demand is a priority in planned care. This will require investment in infrastructure, equipment, and staff to improve access and reduce waiting times for diagnostics and treatment.

Ensure There Are Two Community Diagnostics Centres in Place
Working with the national diagnostics programme, we intend to deliver our ambition of providing two Community Diagnostic Centres (CDCs) in this geography.

Increase and Sustain Efficiency Levels Through New Models of Care
This will require innovative approaches to care delivery, such as remote monitoring and telehealth, to improve efficiency and reduce waiting times.

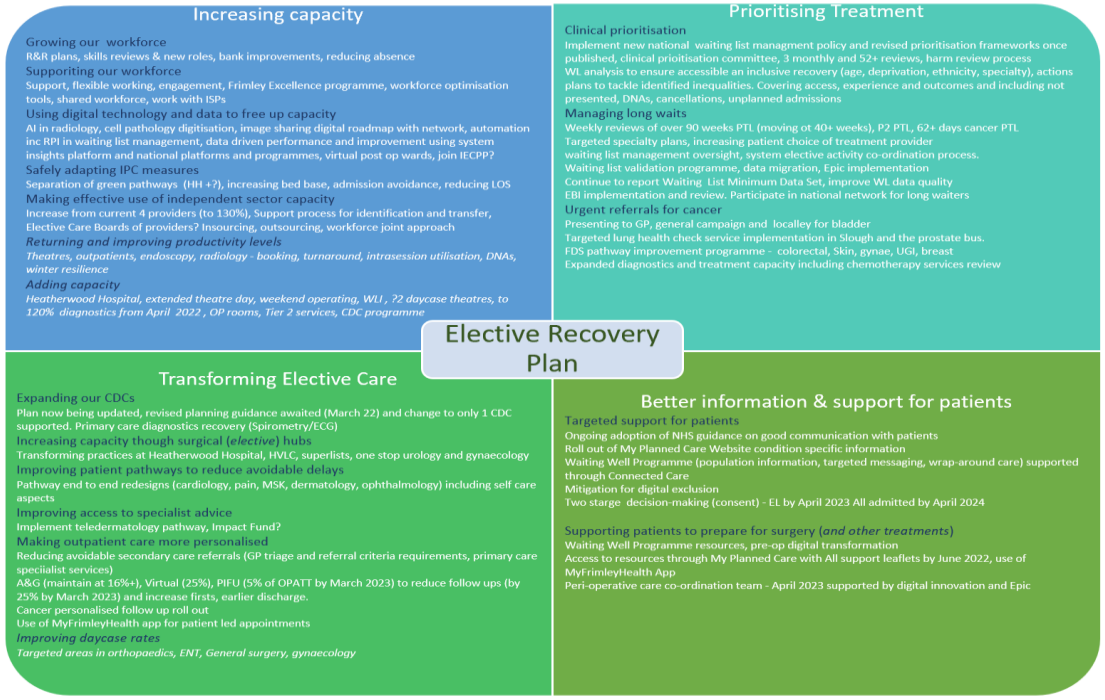
Deliver a Minimum 10% Improvement in Pathology and Imaging Networks Productivity by 2024/25
This is an ambitious stretch which will enable us to significantly increase patient throughout across a range of Planned Care pathways.

Maximise Patient Led Care Models and improve Patient Experience
Maximising patient led care models is a priority in planned care. This requires effective communication, collaboration, and coordination between healthcare providers and patients to ensure that patients have a say in their care and treatment plans.

Further Develop and Utilise Digital Platforms to Support Care
This will require investment in technology and infrastructure to improve access to services, reduce waiting times, and increase efficiency.

Reduce Inequity of Access to Planned Healthcare

We will deploy targeted interventions for specific groups, improving access to services, and addressing the root causes of health inequalities to ensure that everyone has access to quality care.



7. Planned Care – Dependencies, Enablers, and Risks to Delivery

Risks associated with 23/24 plans

Risks/Issues	Mitigation
Availability of insourcing capacity due to high local self pay demand	Further review potential activity with providers outside the area
Loss of activity due to EPR	EPR programme optimisation phase
Ability to achieve additional activity internally with existing staff working additional hours	Ensure agreed payment plans and are in line with local market
Availability of workforce to support addition activity	Workforce plans for higher risk areas in theatres and radiology
Capacity/appetite for GPs to undertake new roles may be affected by severe staffing shortages, although local intelligence and experience shows these roles may be attractive and contribute to GP retention overall	Review potential local demand before designing new pathways dependent on this workforce
Leadership and management teams are busy with UEC pressures and there may be difficulties in making sufficient resource available to lead and manage change projects and contracted outsourcing activity	Ensure ring fenced capacity is maintained through ongoing support for senior leaders
Difficulties providing sufficient face to face and virtual outpatient capacity to support non-admitted push	Capital works in progress to stand up further physical capacity. Plan for additional resource. Improve room utilisation through efficiency project
Lack of uptake from our communities experiencing health inequalities for the new offers	Use learning from vaccination programme. Link with regional and national networks for support
Loss of activity capacity due to RAAC plank works to theatre roofs at Frimley Park Hospital	This will be mitigated through phasing of works to reduce impact to as low as possible and ensuring elective surgery booking in priority order and undertaking additional non-admitted activity
There remain risks to the ability to recruit and retain staff in key areas for BAU activity that are being mitigated through the overall workforce programme	See workforce programme
Workforce to support the transformation and delivery is limited	Further role out QI programme including training and mentoring
A significant minority of residents do not speak English and some of the digital offers (including NHS App) are in English only which requires further work	Further work is required on this
Inequalities due to digital poverty	Link with wider ICS programmes tackling this
Delay in ability to deliver more due to technical issues with the EPR	Executive led stabilisation programme
Dermatology remains a concern due to national shortages of appropriate staff	This is expected to be mitigated by ongoing work to reduce unnecessary referrals to secondary care
The pain service is difficult to staff to meet current treatment demand.	This is being mitigated through outsourcing in the short term and in the longer term through a new clinical model that reduces the need for interventions
ICS pain pathway programme does not deliver reduction in treatment demand	Robust programme management with clinical oversight
Reduction in bed availability due to emergency and covid pressures	Improve day case rates to mitigate, use of elective hub where possible. Source overnight activity in preference form ISPs

Forward risks

- Workforce capacity
- Use of digital technology
- Capital funding for new sites/expansions
- Revenue funding for additional workforce and non-pay costs
- Capacity and capability for change and improvement
- New hospital programme

Dependencies

- National CDC programme support
- Workforce plan delivery
- Ongoing work with Connected Care
- Close working across primary and secondary care

Enablers

- New elective Hub
- Frimley Excellence QI
- Digital transformation support
- Capital developments to deliver CDC activity increases

8. Maternity and Neonatal – Strategic Context

Strategic Context

Local Maternity and Neonatal Systems (LMNS) were established in 2017, galvanising stakeholders to join together in implementing recommendations from the Better Births review under the direction of the Maternity Transformation Programme. Since then LMNSs have partnered local leadership in addressing the challenges facing maternity and neonatal services, focussed on improving experience and outcomes for women, birthing people, and their families. The Ockenden Review in 2020 and the Kirkup report on Maternity Services in East Kent in 2022 have crystallised some key areas of focus and improvement.

The Ockenden review required Trusts to demonstrate compliance and provide evidence against a number of essential immediate actions. Frimley were held as an example of good practice in their evidence provision. Reassessment of compliance for the Ockenden visit from regional leads in August 2022 led to a some indicators being judged as amber, from green, due to the requirement to audit compliance and the challenges in achieving this with the new electronic patient record system. Compliance is reassessed quarterly and presented to LMNS and Trust Boards.

The East Kent review highlighted the importance of kindness, compassion and civility within the workforce and towards women, birthing people, and their families. Workforce challenges can lead to human factors impacting safety. Kind, compassionate, personalised care will improve outcomes and safety. The national target to halve still births, neonatal death, brain injury and maternal death faltered in 2021 following several years of a decreasing trend and we will reflect NHSE's re-invigorated aim to reduce these events.

NHSE will be publishing a Single Delivery Plan for maternity in March 2023 bringing together themes from the Maternity Transformation Programme, the Ockenden and East Kent reports. Our Frimley plan will be reviewed and adapted to reflect the Single Delivery Plan. In the meantime, we are able to identify some key priorities based on the anticipated content of the Single Delivery Plan coupled with our own local analysis and need.

Our recruitment and retention challenge mirrors the wider Frimley community and that across health and social care. From maternity support workers, scanning professionals, to midwives, medical and neonatal staff and health visitors, there is workforce insecurity. National and local initiatives combine to address the challenges, increasing pipeline, broadening support for staff, analysing recruitment and retention themes. Ockenden and local funding has been committed so that our core midwifery establishment is in line with birth rate plus, which is currently the accepted tool to calculate safe staffing levels in maternity services. We have work to do to recruit, retain and support staff, in collaboration with our local communities as well as national bodies. As part of our equity programme we are finding ways to support our people from Black, Asian, and minority ethnic backgrounds, working towards representation across bands, and reflecting our community.

In September 2022 we published our equity plan which, as well as raising workforce inequalities, highlighted the gap in outcomes and experience for women from more deprived areas and from Black, Asian, and minority ethnic backgrounds. From late booking, folic acid intake, and perineal injury, through to still births and neonatal deaths, we found inequity in the experience and outcomes of women and birthing people.

The opportunity to improve outcomes for women, birthing people, and families from pre-conception through to the first months of a baby's life continues to drive our programme and we are engaging with our public health teams and wider stakeholders to influence healthy behaviour choices and population health.

8. Maternity and Neonatal – Key Challenges

Challenges for the next five years

Although birth rates have reduced over recent years both nationally and across the Frimley population, a converse post covid increase, higher acuity and women, choosing to give birth in Frimley means that workforce requirements have not reflected that reduction. The current schedule for antenatal care and safety initiatives such as saving babies lives and 'gap and grow' have increased scanning requirements, induction, and caesarean section rates, with a consequent increase in staffing requirements. Establishment increase, in line with birth rate plus, led initially to higher vacancies. Currently vacancy rates vary from 5% to 20% across the range of staff involved in maternity and neonatal care in the acute trust. Further work is required to understand the picture of health visiting team vacancies. Challenges across staff groups vary from health visiting colleagues TUPEs and varied hosting arrangements; substantial increases in midwifery student placements needing to be supported and neonatal leaders having a stretched focus across the paediatric remit.

Our maternity digital strategy identified a range of challenges and opportunities. The move towards hub-working enables midwives to integrate within a multi-professional team, however, the connectivity available does not yet fully support integrated working. There is a challenge with individual organisations using different networks and digital infrastructure. Although the new electronic patient record system, EPIC, is now embedded in providing patient care, information is not yet flowing well to health visitors and GPs and data collation and retrieval from EPIC is not yet providing the insight required. Capacity to resolve the remaining issues with EPIC and maximise it's potential has been limited and will take some time to reach maximum benefits.

Maternity hubs have been heralded in Better Births and the Leadsom review. Although none of the Frimley councils were selected for family hub funding, the maternity hub model has been pursued as a way of supporting an integrated approach and delivering the Continuity of Carer model. Maternity hubs were included in the integrated care hub (ICH) programme in Slough, Bracknell, Maidenhead and Windsor. The ICH programme is broadly paused and with it, maternity hub plans. There is a challenge in identifying medium and long term estate solutions depending on how the ICH programme develops and appropriate finance is secured. Workforce modelling and estates expertise to our programme continues to be a challenge. The maternity hub serving our Surrey women and birthing people is located in Frimley Park Hospital. This does not reflect the community model well and also is an additional pressure on the Frimley Park capacity.

Our equity analysis has very clearly highlighted that not all women have the same experience and outcomes. For example: maternity information is not always accessible; information is not always translated into all key languages; translations require additional time and funding; there are a range of translation offers available and often our local workforce who are multilingual question the accuracy of translations; we know that families may not be able to easily read information even if it is translated; women and birthing people in Slough and North East Hampshire are less likely to access perinatal mental health support than other areas in our system; women and birthing people from Black, Asian, and minority ethnic backgrounds are less likely to share and complete our feedback surveys.

Listening groups and WRES data have found that our staff from Black, Asian, and minority ethnic backgrounds are less likely to progress within their careers and more likely to have a negative experience.

Feedback from our maternity voices partnership tells us that women do not always feel listened to. This mirrors the national picture and is flagged in East Kent and Ockenden reports. Workforce challenges are key in the human factors contributing to care. The East Kent report highlighted the need for compassion and kindness between staff and for women, birthing people, and families. Implementing these core principles will be key to improving care, experience, and outcomes. Our 2022 CQC survey results showed some positive trends with improved response rate including from Black, Asian, and minority ethnic women and birthing people.

8. Maternity and Neonatal – Our Five Year Priorities

Five Year Priorities, Transformation, and Impact and Benefits

The Single Delivery Plan will define national priorities and shape local plans.

We want to grow our workforce and support them to excel. The midwifery leadership have developed a comprehensive workforce plan which has been shared at our LMNS Board and includes international recruitment, increased student capacity, and retention initiatives. Specialist 'Recruitment and Retention' and 'International Retention' roles alongside practice development leads are progressing midwifery and maternity support worker fill rates. Our plan for the next five years is to fully understand trends and highlight challenges across the wider perinatal workforce. We would like to reduce our overall vacancy rate and particularly our midwifery vacancy rate to less than 5%. We plan to support shared learning across our health visiting and public health teams to highlight where innovative initiatives have reduced workforce pressures. The East Kent report particularly highlighted how key leadership and culture is. We will work with our people leads and implement national initiatives. Our leadership team have embarked on the national leadership programme and we look to build on this and our human factors, civility, and allyship training.

We will get better at listening to women, birthing people, and their families, and personalising care. We will focus on education and training, implementation of initiatives such as our Independent Senior Advocate and engagement with our maternity voices partnership. We will aim towards even kinder, compassionate and safer care.

Our equity plan published in 2022 sets out our five year vision to address inequalities of outcomes and experience for women and birthing people and the experience of our workforce. Over the next 5 years we aim to establish structures and governance to oversee the delivery of that plan, engaging with women and birthing people through communities, voluntary sector and our maternity voices partnership. We will ensure women, birthing people, and families have information and support, translated and in accessible formats. We will ensure services target women and birthing people with poorer outcomes and support is directed in that way. We will build on the qualitative and quantitative information gathered from our Black, Asian, and minority ethnic workforce, implementing their ideas to improve career development, support and experience.

Working closely with our public health colleagues we will focus on the high impact areas for pregnancy from pre-conception through to post natal care. We will build on the #ReadyforPregnancy campaign to influence healthy decisions. We will embed and expand our in house stop smoking service and breast feeding peer support. We will seek out training to influence diet and exercise in pregnancy and beyond, flagging opportunities to support women at high risk of, or with gestational diabetes. We will work on ensuring that our public health advice is culturally sensitive and appropriate. We will develop culturally sensitive, non-stigmatising support for families in close relative marriage.

Our Community Hubs will grow and develop as a building block for Continuity of Carer and as a centre for women, birthing people, and families to receive one-stop care. We will take advantage of the opportunity to educate and influence in these community settings. Working closely with our voluntary sector organisations we will map other community assets where we can sign post to and which can be used as engagement forums. When we have achieved a stable workforce with below 5% vacancies, we will trigger our phased Continuity of Carer plans.

The impacts and benefits will be offering safer, kinder and more compassionate care from a better supported workforce. Our dashboards will capture trends in outcomes including still birth, neonatal death, brain injury, and maternal death. Workforce dashboards will flag fill rates against establishment. Qualitative data and engagement will be key to understanding experience of staff and families.

8. Maternity and Neonatal – Our Priorities for 2023/24

Priorities for 23/24

- Consider the Single Delivery Plan (when it is published) and how we organise ourselves as a system to deliver this
- Develop and support workforce initiatives
- Host a workshop for health visiting and public health leads to explore health visiting workforce challenges, and potential solutions
- Develop data capture and sharing across data sources including EPIC, Operational Delivery Network, Connected Care, public health, and workforce, to provide a clear overview of the programme and impact
- Maximise information sharing through EPIC Care with Health Visitors and GPs
- Implement a one year communications plan for maternity
- Review existing and potential resources and capacity to support-maternity website, Solihull, Healthier Together including maternity app
- Establish our Equity Steering Group
- Improve accessibility of our resources with translations and videos
- Work with voluntary sector organisations in engaging with our community
- Highlight and implement key workforce recommendations from our listening groups
- Ensure service development focuses on those with the poorest outcomes
- Establish our Close Relative Marriage group and service
- Progress key areas within the digital strategy, including connectivity
- Embed and develop maternity hubs, securing a community venue in Surrey and aligning with the ‘integrated care hub’ programme and place leads
- Collaborate with partners on influencing diet, exercise, infant feeding, smoking, and mental health
- Establish a network of breast feeding peer supporters
- Expand our tobacco dependency advice offer to Rushmoor, and fully maximise the service
- Finalise our ‘at risk of gestational diabetes’ leaflets
- Support the working group to improve access to perinatal mental health and maternal mental health services
- Support our maternity voices partnership in their work plan, including diversifying their membership
- Recruit and establish our Independent Senior Advocate

Continue to implement:

  - Ockenden recommendations
  - Prem 7 initiatives on pre-term birth
  - Saving Babies Lives
  - Reducing admissions of full term babies to neonatal units (ATAIN)
  - Maternal Medicines Networks

8. Maternity and Neonatal – Dependencies, Enablers, and Risks to Delivery

Dependencies

- There are interdependences with gynaecology, workforce, children and young people, personalised care, mental health, and prevention. There are examples of joint working across all of these areas

Digital

- Many of the issues highlighted in the maternity digital strategy are common across the system
- In order for integrated working to succeed it is imperative that there is connectivity in community venues and the ability for teams from different organisations to work in a seamless, fluid way, sharing information and infrastructure
- The ability to capture, collate, and present, perinatal data from a range of sources to give a clear picture of the challenges, successes, and trends, and particularly where to target resources

Estate

- A comprehensive system wide estates plan incorporating maternity hubs and services. A system wide back up plan where Integrated Care Hubs are not progressing
- Support in maximising potential with existing hubs where there are estates challenges. Support in identifying estate in Surrey to move the community maternity hub from Frimley Park Hospital

Finance

- We are anticipating that the LMNS and maternity funding will be adequate. The ICB finance account management will identify various LMNS funding streams and work with the LMNS lead to transfer appropriate portion to the Trust.
- Ability to spend funding against agreed spending plan

Communications

- Support to review existing resources and maximise impact going forward. Support for promotion and campaigns, particularly maternity communications calendar
- Support for maximising benefit of translated material
- Developing voluntary sector forum to enable community engagement and health messaging

Risks

- Single Delivery Plan delayed or not as expected
- Workforce continues to be challenging and recruitment may not be successful
- Lack of wider system capacity to support

9. Urgent and Emergency Care – Strategic Context (1)

Introduction

Transformation and recovery of Urgent and Emergency Care (UEC) services is one of our top priorities for the Frimley Health and Care ICS. Providing timely and effective care in emergency situations is vital to saving lives, reducing long-term harm, and improving the overall health outcomes of our population. Prior to the publication of this Joint Forward Plan, we have been working as a partnership on a multi-year whole system UEC strategy aimed at ensuring that our population receive the care they need, when they need it.

In recognition of the importance of this issue, the ICS has signalled its intention to make significant improvements in this area. As part of this commitment, we undertook a whole UEC Review and Strategy Refresh during the summer of 2022. This section provides a summary of the refreshed strategy and outlines the key areas of focus for the ICS in the coming years.

The Importance of UEC

UEC services provide urgent and emergency care to patients who require immediate medical attention. These services are crucial in preventing serious medical conditions from worsening and can often be the difference between life and death. In recent years, UEC services have come under significant pressure due to increased demand, changing demographics, and staffing shortages. As a result, UEC services have struggled to meet the needs of patients, and wait times have increased, leading to significant challenges in providing timely and effective care.

The Joint Forward Plan

The Joint Forward Plan is a five-year strategy that aims to address the challenges faced by UEC services and improve the quality of care provided to patients. The plan sets out a clear vision for the future of UEC services and identifies the key areas of focus for the ICS. These areas of focus include improving patient flow, enhancing the resilience of services offered outside of hospital settings and improving longer term population health.

Improving Patient Flow

One of the primary goals of the UEC Strategy is to improve patient flow through UEC services. This involves streamlining the patient journey, reducing wait times, and ensuring that patients receive the right care as quickly as possible. To achieve this goal, we will work to improve the integration of UEC services with other healthcare providers, such as primary care and social care. This will help to ensure that patients receive the most appropriate care and reduce the burden on UEC services.

Enhancing the Quality of Care

Another key focus of the Joint Forward Plan is to enhance the quality of care provided to patients. This involves improving the skills and knowledge of UEC staff, implementing best practice guidelines, and ensuring that patients receive safe, effective, and compassionate care. The partnership will work to develop a culture of continuous improvement, where staff are empowered to identify areas for improvement and make changes to improve the quality of care.

Right Care, Right Time, Right Place

The final area of focus for the Joint Forward Plan is ensuring that patients receive the right care, at the right time, and in the right place. This involves improving access to UEC services, providing a range of options for patients, and ensuring that patients receive appropriate care in the most appropriate setting. To achieve this goal, the partnership will work to improve the coordination of UEC services with other healthcare providers, such as primary care, community care, and social care.

Summary

This section of the Joint Forward Plan is a critical part of our collective efforts in ensuring that patients receive timely and effective care. The plan sets out a clear vision for the future of UEC services and identifies the key areas of focus for the ICS. By improving patient flow, enhancing the quality of care, and ensuring that patients receive the right care, at the right time, and in the right place, we will improve the overall health outcomes of patients and provide the best possible care to those who need it most.

9. Urgent and Emergency Care – Strategic Context (2)

Supply side challenges

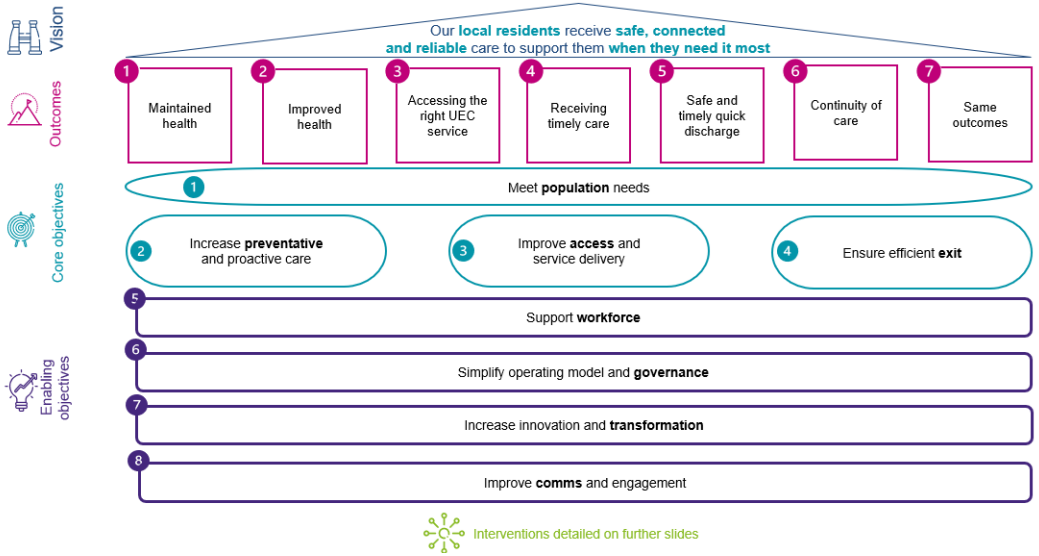
- Significant additional system capacity
- 21% increase in hospital length of stay in the last 2 years across the patch
- c.20% beds filled by Medically Optimised patients at any one time
- Patients with a LOS greater than 21 days – c.80% higher year on year, equating to >160 more patients
- Elective and diagnostic capacity reduced due to estates safety concerns at Frimley Park (RAAC Plank failure risks) and other service pressures
- Additional capacity for elective care protected by successful build and implementation of new cold site at Heatherwood Hospital
- 93 additional beds supplied through the ”Virtual Ward” programme with Frimley providing regional clinical leadership in this area

This imbalance results in material access and quality constraints and is not sustainable

Demand side challenges

- Frimley General Practice appointment activity per working day is up 10.5% year on year
- 16% more General Practice appointments provided than pre-pandemic despite shrinking General Practitioner workforce
- 10.3% increase in 111 activity since 2019/20
- ED peak activity levels, OPEL 4 and critical incidents occurring more frequently than prior to 2020
- 6.5% of patients waiting more than 12 hours in ED
- Increase in acuity of admissions from ED

9. Urgent and Emergency Care – Key Challenges



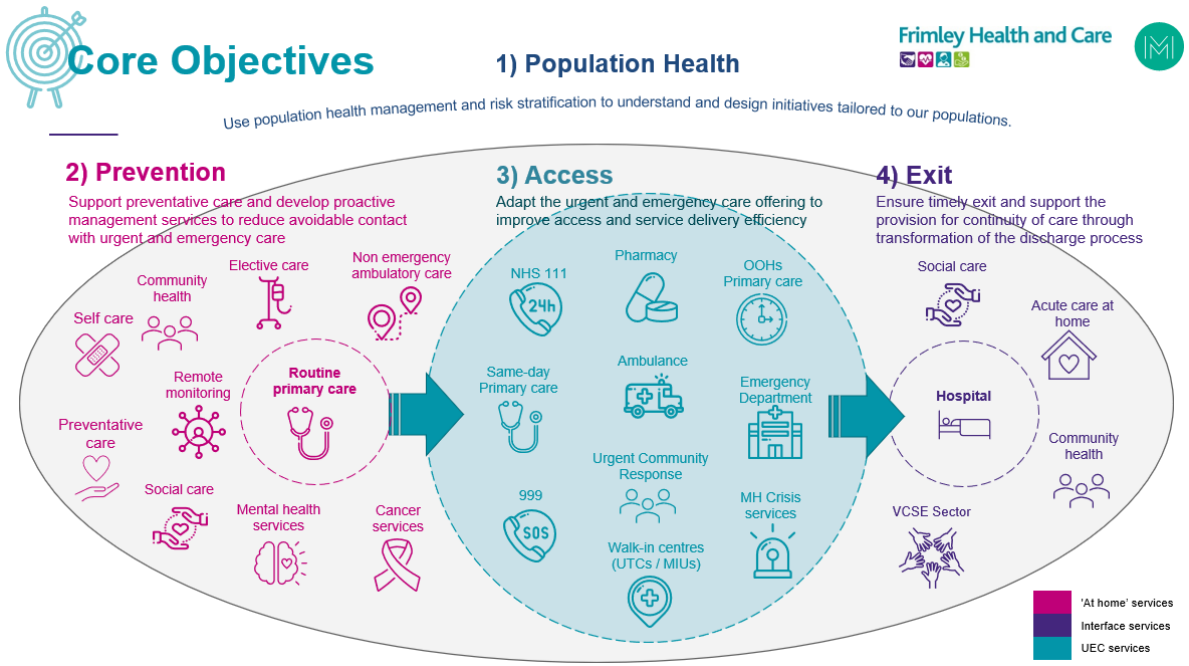
We have worked as a whole system partnership to develop a review of UEC services. This work is informing a strategy for long term transformation of the whole system drivers of challenges in this sector.

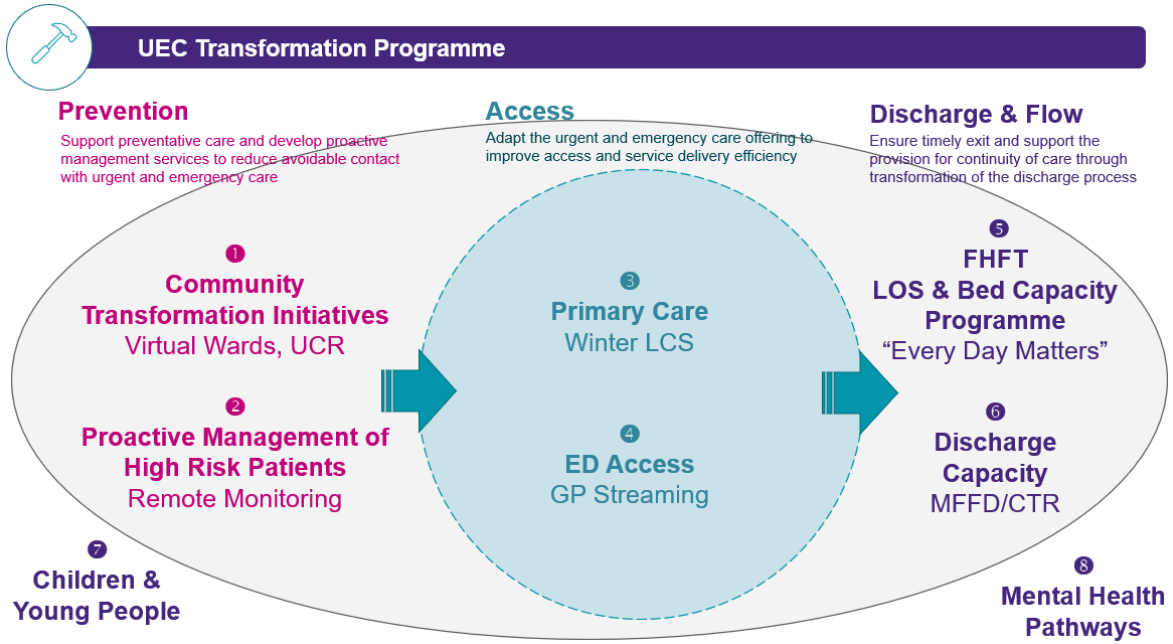
A range of inputs were captured and synthesised in developing the strategy to shape interventions that will optimise delivery of UEC in Frimley in the years ahead. These include:

- Consultation with 132 stakeholders across health and care
- Insight drawn from Frimley data analytics spanning all areas of the UEC system
- Review of 60 international, national and local best practice to inform recommendation
- Content development tested with independent Subject Matter Experts
- Four Core Objectives identified across Population Health, Prevention, Access and Exit, and a further four Enabling Objectives identified to support delivery
- 17 interventions developed to enable the system to deliver each of these Core objectives to support implementation, with a further 15 interventions to support the four Enabling Objectives

Core Objectives	Interventions
1. Understand the needs of our population to deliver equitable clinical outcomes system-wide and reduce health inequalities	1.1 Use a population health based management approach to identify and act on opportunities to increase preventative care and reduce risk of health deterioration 1.2 Support our at risk population to better manage their conditions through risk stratification and development of targeted personalised initiatives 1.3 Reduce variation of knowledge and use of services across the system through better understanding and alignment, supported by an enhanced Directory of Services 1.4 Reduce unwarranted variation in UEC service use and clinical outcomes linked to geographical differences
2. Support preventative care and develop proactive management services to reduce avoidable contact with urgent and emergency care	2.1 Expand and roll-out remote monitoring initiatives that support the management of people in the community/ at home 2.2 Expand and roll-out digital tools that support proactive care and self care 2.3 Increase outreach of specialist care to support MDT working within integrated models of community care
3. Adapt the urgent and emergency care offering to improve access and service delivery efficiency	3.1 Increase same-day urgent care capacity outside of the acute and routine primary care via a same-day access hub model 3.2 Increase and optimise use of community services such as pharmacies, urgent community response teams and point of care testing to support primary care demand 3.3 Maximise use of alternate pathways that are available to ambulance services to limit avoidable ED conveyance 3.4 Reassess and refresh the implementation of the 111 service locally to maximise its capacity within CAS and support the service to direct patients to the right service at the right time 3.5 Improve access to moderate and low grade acuity CYP mental health services through IAPT, to reduce occurrence of escalation to UEC mental health services 3.6 Strengthen and enhance standardised pathways for cohorts with specific needs
4. Ensure timely exit and support the provision for continuity of care through transformation of the discharge process	4.1 Support the management of discharge through timely patient care data sharing and fully visibility of capacity and demand data between acute and community/social care providers 4.2 Use demand, capacity and activity data in order to undertake strategic commissioning tailored to local communities 4.3 Realign the system wide discharge function through improved governance, alignment of risk approach and provision of a neutral decision making to coordinate discharge between providers 4.4 Use UEC resources to increase social care capacity to support efficient and safe discharge of patients

9. Urgent and Emergency Care – Our Strategic Priorities





Our approach has been to translate our four Core strategic objectives into an immediate UEC Transformation Programme.

Eight priority workstreams have been established that together ensure patients continue to receive first class UEC services.

We've also established a clinically-led UEC Strategy Group to oversee the implementation of the strategy to progress the longer-term objectives

9. Urgent and Emergency Care – Our Priorities for 2023/24

The national UEC Recovery Plan was published on 30 January 2023, and our response sits within the System Operating Plan for 2023/24. Our plan is credible, achievable and is being overseen by the UEC and Planned Care Board and system working groups, which span organisational and sector boundaries. The priority workstreams within our plan are described below, including what is being delivered to increase resilience, outcomes and experience for our patients and residents throughout 2023/24.

Plan Key Points	Community Transformation	Proactive Management of High Risk Patients	Primary Care Transformation	ED Access	FHFT Improvement Plan	Additional Discharge Capacity	Children and Young People	Mental Health	Supporting our local people to access the care they need at the right time
What this means	Building additional capacity in the Community/non-acute hospital and VCSE hospices sector by using a full range of physical and virtual care alternatives	Supporting patients who are most at risk of hospital admission with virtual solutions to manage their condition safely out of hospital	Creating greater access and resilience in the primary care sector to ensure the needs of residents can be met more quickly	Building new pathways and capacity to provide multi-disciplinary clinical support to reduce long waits in emergency departments	Improving bed availability by reducing admissions to the core G&A bed base and improving flow through the available bed base	Ensuring that those patients who are ready to leave hospital are able to move onto their next appropriate setting of care	Directly supporting younger age groups with the help they need to ensure their social conditions and health needs are met	Resilience for services that support those who are in crisis to ensure their needs are provided in an appropriate care setting	Implementing transformative improvement projects at pace to build greater system resilience and quality of care for our population
What are we doing to progress this	Urgent Community Response embedded and fully functional. 91% of patients seen <2hrs (vs 70% national benchmark). Seven virtual wards fully operational across Frailty, UEC, Respiratory and Palliative Care. NHSE Regional Clinical Lead (Dr Lucy Abbot) seconded from the Frimley Integrated Care System to support development	Support up to 20,000 complex and frail patients and Care Home residents using remote technology via two centralised monitoring hubs (EBPC- NEHF, RBWM and Slough; BPC- Surrey Heath, Bracknell and Ascot). The roll out of remote monitoring to care homes will continue across 135 homes. On track to ensure 5,500 patients passed to digital health team by the end of 2023.	Invest £1.2m to support the identification of 60,000 primary care additional appointments over a 20 week period. Additional appointments focused on respiratory capacity utilising the ARI project. Enabling Primary Care Networks to mature their same day urgent care models in the community	A Minor Injury and Minor Illness Task and Finish Group has been established to devise the system model of care for Same Day Urgent Care. This will encompass primary care, out of hours services, our two ED departments, community pharmacies and a system wide approach to urgent treatment centres	In addition to the Acute Front Door Task and Finish Group, Task and Finish Groups have been established for: 1) 0-72 Hour Pathways,2) Admitted Patient Flow; and 3) Clinical Site Management. These will oversee the rapid and overall improvement of those departments and functions	Use of the workstreams within the Discharge and Flow Transformation Programme Plan to: - improve the process of complex discharge - ensure efficient and optimal use of available discharge capacity and resource - identify further potential capacity; evaluation of schemes for benefit, sustainability and value for money	Focus on Low Needs children and their reasons for presenting to urgent care services. Universal raising profile of Frimley Healthier Together to support self-care. Targeted interventions to communities of focus who need additional support to self-care, identified through data insights	Enhance offer to intervene early, prevent admission and keep people at home. Expand safe havens. Increase crisis beds. NHS111 with MH option. Specialist MH expertise for Police and Ambulance and enhanced MH transport offer. Ensure flow in/out of inpatient units through discharge hubs, CRFD panels, home first offer	Delivering on our Plan to ensure that additional support is in place ahead of the most acute periods of the Winter period Working across organisational boundaries to innovate with health and care professionals Putting the needs of residents and patients at the forefront of our plans
How this is supporting improved performance	• More capacity for patients and residents to access the care they need • Using data and technological innovation to drive improvement from new opportunity areas				• Greater service resilience as a result of a credible and deliverable plan • Pan-system leadership and support from all parts of the public sector to meet the needs of the public				

9. Urgent and Emergency Care – Critical Success Factors

Our Strategic approach includes four Enabling Objectives in the areas of Workforce, Governance, Digital, and Comms and Engagement. Fifteen Interventions sit across these Objectives as shown below. We have identified four Key UEC Risks, which we monitor through the UEC and Planned Care Board.

Enabling Objectives	Interventions
Adopt alternate workforce solutions that develop and support the UEC workforce to provide the right care for patients	5.1 Diversify workforce to take advantage of non-traditional roles and ensure skillsets match service delivery 5.2 Increase career progression and development pathways to provide opportunities for our local communities 5.3 Create a UEC system wide workforce model and mature resource sharing models across health and care
Implement a system wide UEC operating model to share risk, reduce complexity and support a more resilient, sustainable system	6.1 Reconfigure the UEC board to maintain focus on high priority challenges, ensure efficient commissioning, create clear delineation of shared responsibility and strengthen individual accountability 6.2 Define shared KPIs and SLAs and consider collective funding models to drive towards common outcomes 6.3 Develop a UEC demand and capacity model that is visible across the system 6.4 Define and apply clinical risk thresholds across the system in order to share risk appropriately and ensure efficient operational flow occurs 6.5 Pursue a UEC system wide simplification programme 6.6 Undertake an internal culture change initiative to improve interactions with patients around UEC
Continue to transform how care is delivered by embracing opportunities to innovate and lead on best practice care	7.1 Establish mechanisms, funding and infrastructure to support innovation and implement successful pilots across the system 7.2 Support better management of patients by using advances in predictive analysis, AI and NLP including implementation decision making support tools through the UEC pathway 7.3 Ensure partnerships with the private sector are delivered effectively through rigorous partnering frameworks and evaluation criteria
Improve patient awareness and understanding of how to access the right care	8.1 Target high intensity UEC users through delivering specific and relevant initiatives and communications 8.2 Address language and cultural barriers for patients to effectively engage with UEC 8.3 Undertake a culture change initiative to change perceptions and expectations of UEC

Key Risks				
Risk	**Management of the Criteria to Reside (CTR) numbers**	**Patient harm due to delays in clinical care**	**Overall Bed Capacity**	**Safety and well-being of all staff**
Causes	Capacity in local authority discharge destinations and efficient processes within the acute trust	Demand on health care services out stripping resources, capabilities and capacity	Continual demand out stripping resources	Continual demand and pressures on responding workforce
Effect	Increasing numbers in medically fit patients causing severe blockages in patient flow	Health and safety of patients becomes compromised	Unable to reduce escalation beds utilisation	Sickness and absence rates increasing, Patient safety compromised, Increasing mental health, Issues in recruitment and Retention
	20	**20**	**Risk Rating** **20**	**16**
Controls	- Daily whole system calls - IRIS huddles - Escalation to Gold calls if required - Discharge and Flow Steering Group (monthly)	- Surge and Escalation Protocol and supporting action cards - Ability to set up System Gold Calls with all Health Partners - Ability to seek support from Multi Agency Partners - Ability to seek support from NHSE SE Regional Team - Ability to seek support from Comms messaging to the general public.	- Admission Avoidance schemes e.g., Virtual Wards - Comms messaging re Patient Choices	- Wellbeing and support offers available within each organisation
Issues	Ongoing demand and continued pressures on whole system including health Partners	Continuing pressure and demand on the System	Continual demand on whole system health and care partners	Continuing demands and pressures on responding workforce
	16	**16**	**Residual Rating** **16**	**12**

10. Comprehensive Model of Personalised Care – Strategic Context

Frimley Health and Care ICS aims to empower our local population to take more responsibility for their own health and wellbeing by working together with our partner organisations to support them to make healthier choices, manage their own conditions, and have better health outcomes addressing health inequalities.

Our People Place and Communities strategic ambition is about “doing with”, not “doing to” people. Through the work of this ambition, the 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 **Changing the conversation** with individuals to design and **deliver solutions together** understanding what matters to our population.

Personalised care is one of the five major practical changes to the NHS as detailed in the NHS Long Term Plan. Personalised care means people have more choice and control over the way their care is planned and delivered based on ‘*what matters to me*’ , meaning their individual needs and preferences to support them staying well for longer, which will deliver better health and wellbeing outcomes. The Comprehensive Model of Personalised Care outlines how we will deliver this cultural shift by bringing together six evidence-based components:

Personalised Support and Care Planning

Shared Decision Making

Enabling choice, including legal rights to choose.

Social prescribing and community-based support.

Supported self-management.

Personal Health Budgets and integrated personal budgets.

The Personalisation programme is incorporated within the People Places and Communities strategic ambition to deliver the Comprehensive Model of Personalised Care, making it a golden thread through everything we do and an everyday reality for the people. It is also an enabler to address inequalities in health and social care by supporting disadvantaged or vulnerable groups working in partnership to ensure that care is reaching those who could benefit the most and face the greatest health inequalities.

10. Comprehensive model of personalised care – Key Challenges

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. Working with individuals as partners to help them take more control over their health and achieve their own outcomes will result in better experience for all.

To embed personalised care we need to invest and develop our workforce to have the right conversations. This will require staff to have excellent listening, communication, and negotiation skills, and the ability to respond flexibly to people's individual needs. New ways of working across health, care and the voluntary and community sector will be required to explore different models of contracting and commissioning services to meet patient outcomes.

A whole system approach will only be successful if there is collaboration. People working in partnership with their peers from other parts of the health and care system to deliver more co-ordinated, person-centred care as well as facilitate a positive change in the power of decision making for our patients.

When implemented well, and at scale, personalisation can lead to transformative change that:

- Improves people's health and wellbeing, joins up care in local communities, reduces pressure on stretched NHS and Care services and helps the health and care system to be more efficient.
- Helps people with physical and mental health conditions make decisions about managing their health, living their life based on what matters to them. As well as providing them evidence-based, good quality information from the health and care professionals who support them
- Recognises, for many people, their needs arise from circumstances beyond medicine, connecting support from the communities that surround them.
- Empowering staff to have a different conversation with individuals and communities.

10. Comprehensive Model of Personalised Care – Our Five Year Priorities

Frimley Health and Care ICS are committed to creating a system where people are treated as individuals by professionals they trust.

Working with the Living well ambition we aim to ensure that universal personalised care is embedded to really understand what matters to our population. As a System we want to introduce Anticipatory Care models along with Population Health Management and Personalised Care to reduce inequalities.

Ensuring that we have the right **digital services**, platforms, infrastructure, and standards in place, so people share their story once, resulting in a single integrated personalised care and support plan that is accessible to all involved.

Developing the culture that **Co-Production** and **Co-design** is integral to the delivery of personalised care, modelling the 'shift in relationship' and supporting the necessary culture change. Recruiting peer leaders to work collaboratively with them to build credibility of the personalised care offer in the system.

A whole system approach will only be successful if there is **collaboration** across the system. People working in health and care need to work in partnership with their peers from other parts of the health and care system to deliver more co-ordinated, person-centred care. Ensuring leaders have the knowledge and tools required to embed Personalised Care at system, place, and neighbourhood levels.

Continuing to support our **workforce i**n primary care**,** social prescribers contributing to integrated Cluster MDTs and development of personalised care and support plans and anticipatory and crisis care planning for the most vulnerable adults. First contact Physio skills in Shared decision making and Supporting people to self-manage skill of the First Contact Physios to support patients make decisions about their health and long-term goals.

10. Comprehensive model of personalised care – Our Priorities for 2023/24

During the next twelve months the focus is around strengthening knowledge and capacity of staff and building leadership. The priorities are based on developing the existing work of the personalisation programme along with the ongoing commitments to the NHS long term plan.

- Peer support development for the ARRS (Social Prescribing Link Workers and Health and Wellbeing Coaches)
- Build on existing Personal Health Budgets focusing on opportunities in Mental Health
- Digitalisation of Personalised Care and Support Planning focusing on Anticipatory care
- Continue the launch of the GetuBetter App to support those waiting for surgery or community physiotherapy and rehabilitation.
- Expanding Wellbeing circles to support Families with Children and Young People
- Implementing Proactive care and delivering Heart Failure @ home remote monitoring
- Working with our communities to recruit those with lived experience to support a co-produced offer supporting and developing peer leaders for the system (NHSE programme)
- 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
- 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
- Support from Frimley Academy to provide opportunities for training and development of our workforce to hold community conversations and co-produce plans for improvement
- 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

10. Comprehensive model of personalised care – Key Success Factors

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, work flexibly, invest in models of delivery, and be brave enough to actively target resources where we can make the biggest difference for local people.

Financial investment will be required for training and development of our workforce, capital to support and maintain our digital platform, and leadership capacity to drive this ambitions. Making healthcare more personalised means that people can access health and care services that are better tailored to their needs, make sense to them and focus on what really matters in their lives. We want to empower local people to make healthier choices that support their own health and wellbeing.

The benefits for the system will be:

- Better health and wellbeing outcomes for our population
- Effective co-production methodology and capability at all levels across the system
- Using population health data to targeted wellbeing offers that meets local needs and priorities
- Good conversations with all our communities and that communities feel empowered to have a voice and make decisions that are right for them
- Strong relationships with organisations and the VCSE
- People have choice and can fund care that's right for them
- Identified champions within the system, place, and neighbourhood level to deliver personalisation

Our Shared Approach to Safeguarding

The Frimley ICS Safeguarding Strategy

Safeguarding our individuals and community from harm is a thread that underpins our work.

The ICS workforce, in partnership with families, strive to identify early signs of harm to an individual or community and implement strategies to reduce safeguarding incidents within a domestic or care setting.

The ICB/ safeguarding Strategy is aligned to the ICS Ambitions and includes the priorities set out in the adjacent table.

Delivered and Supported by

Quarterly ICB safeguarding reports demonstrate the progress of these portfolios alongside other significant safeguarding workstreams.

These reports are presented at the Frimley ICB/ICS Strategic Safeguarding Meeting, NHS England, Place Boards and ICB System Quality Group.

These include latest statutory changes, updates on adult and child serious case reviews and domestic homicide reviews and child death overview reports.

It is important to note that this strategy remains flexible and the ability to add any serious local and/or national safeguarding incidents which lead to an immediate change of practice or safeguarding development. Should this be the case, the strategy will be amended accordingly.

Portfolio	Workstream Priorities
Governance	• Work towards production of an ICS wide annual safeguarding report • Agree consistent safeguarding data collections across the ICS • Safeguarding supervision
Children and Young People in Care (CYPIC) and Care Leavers	• CAMHS and Mental health offer for CYPIC, Care Leavers, and unaccompanied Asylum seekers; health provision, equity of health offer, Medical Office Job description reviews (See Children's Chapter)
Implementation of Serious Violence Duty 2022 and Domestic Abuse Act 2021.	• Training offer, Health organisations staff DA Policy, Best practise guidelines for health incorporating new guidance from the Domestic Abuse Act and Serious Violence Duty, Review FGM Pathway and current activity, Work with Community Safety Partnerships to influence strategic plans for violence against women and girls. • Working with community safety partnerships to implement the Serious Violence Duty to reduce serious crime and prevent escalations including knife crime, Exploitation pathways/toolkits/assessments, Respond and support data collection initiatives arising from the Serious Violence Duty, Raising awareness in the community, Training for health organisation
Migrant populations including Asylum Seekers and Refugees	• Health safeguarding teams to be part of multiagency response to new asylum-seeking accommodations, Escalate any acute or thematic safeguarding issues appropriately, Develop best practice principles in line with equity or access for health services for our whole population, Respond in a timely and appropriate fashion to new migrant policy and developments.
Maternity and Early Years	• Safeguarding workforce, share innovations for recruitment and support for practitioners in post, Promotion strategies from CDOP themes and learning including safe sleeping initiatives and water safety, Maternity safeguarding priorities.
Liberty Protection Safeguards (LPS) and Mental Capacity Act (MCA)	• Health systems readiness of LPS implementation, ICB Duty compliance, Improvements to MCA practice improvements

Frimley Health and Care

System Development

Creating the right conditions for delivering our Joint Forward Plan

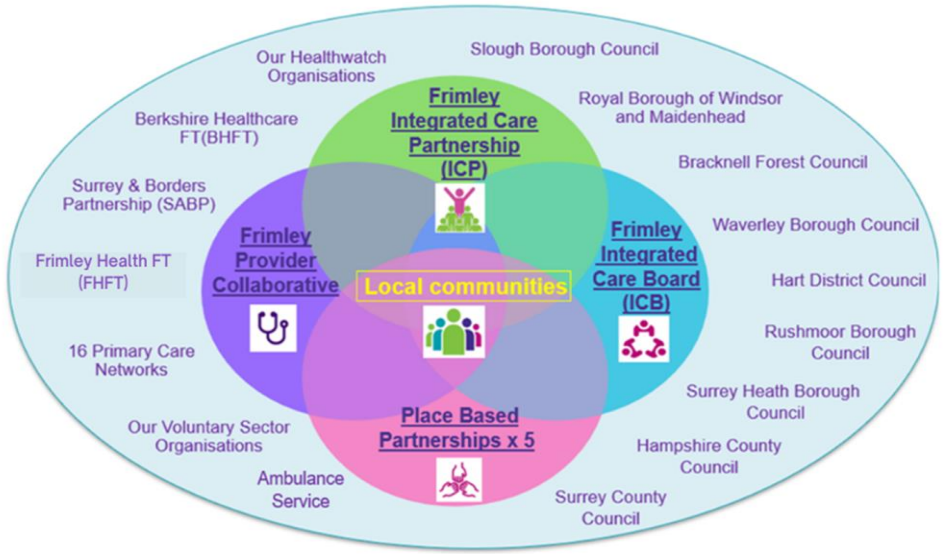
ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR

11. Governance, Leadership and Culture – Strategic Context

Strategic Context

As our system architecture continues to evolve and mature we will continue to develop our approach to governance ('the way we do things') across our system footprint that builds on the core principles of partnership working and distributed leadership. By making decisions together with others and enabling distributed leadership we will be able to mobilise our leaders at all levels of the system, and across our partner organisations, to build capacity for improvement and change in a timely and effective way. We will ensure that our governance reflects a system perspective that:

- Recognises the importance of leadership by expertise (rather than years)
- Builds on high levels of trust, transparency and mutual respect
- Seeks more equitable distribution of decision making and delivery
- Focuses on consultation, engagement and consensus seeking
- Enables change and improvement from the bottom up to flourish



Our approach

Over the next five years we will ensure that the four key constructs of our system architecture (Integrated Care Partnership, Integrated Care Board, Provider Collaboratives and Place Based Partnerships) are working together to ensure we deliver our six system ambitions as set out in our system strategy, our joint five year priorities and annual plans.

Our governance will be underpinned by arrangements that support:

- Clear and transparent decision making
- Fully informed consideration of the balance of risks across safety, quality, performance, finance, workforce and service sustainability
- Decision making at the most appropriate level and made by consensus whenever possible
- Appropriate assurance on deliver of strategy and plans, use of resources and quality of services

We will have a reflective and flexible approach to the governance framework within which we operate that enables our building blocks to flourish so the right decisions are made by the right people in the right places. AS with all new and emerging complex systems the arrangements for today may need to change for tomorrow but the principles of subsidiarity and distributed leadership underpin our approach.

11. Governance, Leadership and Culture – Our Priorities for 2023/24

Priorities for the Year Ahead

Over the next year we have a number of priority areas for focus which are set out below:

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 continue to grow our **Frimley Academy** to nurture our shared leadership culture through offering and expanding access to our flagship system leadership programmes which include:

Frimley Academy
Leadership, Culture and Improvement

- Refreshing and delivering the next cohorts of our 20/20 system leadership programme
- Refreshing and delivering the next cohorts of our system digital leadership programme
- Continuing to work with our system partners to deliver our local Mary Seacole Programme
- Review and reinvigorate our health inequalities programme growing our network of leaders committed and taking action to reduce inequalities through our Frimley 10:100 programme
- Offering our 'thought leadership' development sessions to even wider audiences
- Develop our community of practice so we leverage our people and leadership network for maximum impact

20/20 EMPOWER INNOVATE DELIVER

FRIMLEY 10:100 EMPOWER INNOVATE DELIVER

Wavelength CONNECT EMPOWER TRANSFORM

MARY SEACOLE LOCAL PROGRAMME

11. Governance, Leadership and Culture – Our Five Year Priorities

Strategic Context

As a system we are fully committed to growing our people and developing our culture that enables improvement and innovation to flourish. 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 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.

Over the next five years 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 have a key focus on:

- 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, through our Leadership Academy, 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 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’

12. Provider Collaborative Development – Strategic Context

Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services.

By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities.

Significant scope to deliver these benefits already exists within current legislation and, subject to its passage through Parliament, we expect the Health and Care Bill will provide new options for trusts to make joint decisions.

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience by, for example, providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, Cancer Alliances and clinical support service networks.

Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.

System partners will need to agree the areas of focus and delivery for each type of collaboration and decide how these arrangements can work most efficiently and coherently in a local context to achieve benefits for people and communities.

12. Provider Collaborative Development – Progress to Date

The Frimley ICS Provider Collaborative takes a broad and purposeful view towards the development of a sustainable, collaborative model for the provider sector within a system partnership construct.

Our journey to date:

Our work together in this space dates back to the “Frimley Roadmap” which was published in the Autumn of 2020. Provider Collaboratives were identified as one of five workstreams that would help us achieve our ambitions as a system partnership. This development pre-dated the national policy development of 2021 which required systems to have Provider Collaboratives in active development.

Whilst there is significant variation nationally on how systems are approaching this ask, we want to be inclusive of all partners in the sector, focusing on care improvements rather than governance and recognising that providers are not just hospital Trusts. To this end, we have recently established our new Provider Collaborative Board which has broad representation from GP Provider organisations, Primary Care Networks, the ICB and the three NHS Provider Trusts which serve patients in the Frimley geography.

We have deliberately taken a local interpretation to this work – with less focus on governance or joint working vehicles and more attention on pathway improvement and resident facing opportunities which deliver the overarching strategy.

We will continue to progress our already established programme of work focused on three priorities – which have already delivered some early successes:

i. Ageing Well – UCR established and is operating – still some operational improvements to be made but is a core part of our community offer. Virtual wards as a past of this programme are keeping dozens of patients out of hospital, safely.

ii. Pain – New clinical pathway designed ready for additional engagement and potential implementation – costed and staffed to provide greater equity of outcome for patients across the whole geography

iii. Planned Care Recovery and Transformation – focus on long wait pathways, creating clarity for specialties and referrers and addressing those patients waiting longest.

12. Provider Collaborative Development – Next Steps

As a committed partner of the Frimley NHS partnership, the Frimley Provider Collaborative continues to be ambitious about the role provider collaboration can play in the delivery of this Joint Forward Plan. We believe that working together is the key to achieving better outcomes for our patients and our communities and recognise that although there are still challenges to be overcome, we are committed to working together to find solutions.

Our focus remains on meaningful service transformation rather than structures and governance. We believe that by working together, we can identify the most effective solutions for our patients and our communities. We will continue to collaborate with our partners in the Frimley NHS partnership to ensure that we deliver high-quality care that meets the needs of our patients.

For the 23/24 year, we have refreshed our Provider Collaborative Board. This new Board has greater Place and Primary Care representation, recognising the importance of oversight and direction from a broad array of provider voices. We believe that this will help to ensure that our services are better integrated, more patient-centred, and more effective.

One of our key priorities for the coming year is to increase our focus on elective care transformation and the recovery of long waiting times. We recognise that this is a significant challenge, but we are committed to working with our partners to find new and innovative solutions that will help us to deliver high-quality care to all our patients.

In addition to this, we will also be looking to identify new pathways that could focus on a more collaborative approach to redesign and integration. We recognise that there are often many different organisations and pathways that patients must navigate to use our services, and we believe that by working together, we can identify more effective ways to support our patients and their families.

Ultimately, the success of provider collaboratives depends on effective clinical and executive leadership. By working together in a collaborative and transparent manner, our leaders will create a culture of trust and cooperation that supports the delivery of high-quality care. This is essential for ensuring that patients receive the best possible outcomes and that providers are able to deliver care that is both efficient and effective.

13. Place Development – Strategic Context

Context for Place-based development

Our five places within the Frimley system have a well-established history.

Each has a relationship with a different upper tier local authority, and some with additional lower tier local authorities, without clearly defined and aligned boundaries in some cases.

CCGs were originally established across the five geographies of North East Hampshire and Farnham, Surrey Heath, Bracknell and Ascot, Windsor Ascot and Maidenhead and Slough before the Frimley system was formed.

We now have a single Frimley ICB following the implementation of the Health and Care Act (2022) and have five Places which align more closely with our local authority boundaries, and with an opportunity to redefine the ways of working within those Places and the partnerships they embody.

We see Place as an opportunity for our residents and their families, their communities and the unique characteristics they have to be at the heart of our integrated working at place, with and for those residents, families, communities and our public services.

Process for Place-based development

- Since 2021/22, we have held place development workshops together and continued to have a range of conversations within places and across places.
- Those workshops focused on discussing and shaping:
- Principles of place-based working, their strengths and alignment with heath and well-being boards
- Role and purpose of place, relationships and ways of working for success
- Enabling elements to support places: people and capabilities, joint decision-making approaches, benefits and opportunities of pooled budgets

The **Integration White Paper** continues to be considered and offers a further framing for our ongoing development of our five places, in the context of the more mature shaping we have agreed across our ICP, ICB, and Provider Collaborative structures.

13. Place Development – Next Steps

Our aspiration for the development of Place based working

Our aspiration for the development of place-based working in our health and care system is to create a model of care that is truly person-centred and responsive to the needs of our local communities. We believe that by working together, we can create a system that is more integrated, efficient, and effective.

Our vision for place-based working is centred around five key principles:

- **Collaboration**: We believe that effective place-based working requires a collaborative approach that brings together stakeholders from across different sectors. This includes healthcare providers, local authorities, third-sector organisations, and patients and their families.
- **Co-design**: We believe that place-based working requires a co-design approach, where stakeholders work together to develop solutions that meet the specific needs of each community. This means involving patients and their families in the design of services and empowering them to take an active role in their own care.
- **Local leadership**: We believe that effective place-based working requires local leadership that understands the unique challenges facing each community. This means working with local leaders to develop solutions that are tailored to the needs of each place.
- **Innovation**: We believe that effective place-based working requires an innovative approach that is open to new ideas and new ways of working. This means exploring new technologies and new models of care delivery that can help to improve outcomes for patients.
- **Data-driven**: We believe that effective place-based working requires a data-driven approach that is informed by the latest evidence and best practices. This means using data to identify areas for improvement and to measure the impact of interventions.

Our aspiration is to create a place-based working model that is grounded in these principles. This will require a collaborative approach that brings together stakeholders from across different sectors to co-design solutions that are tailored to the unique needs of each community. We will work with local leaders to develop innovative models of care delivery that are informed by the latest evidence and best practices.

In order to achieve our aspiration, we will need to build strong partnerships with stakeholders across different sectors. This will require a commitment to open communication, trust-building, and a willingness to work together towards the implementation of our *People, Places and Communities* strategic ambition as defined in the ICS Strategy, *Creating Healthier Communities*.

Evolution of the Integrated Care Partnership

The Integrated Care Partnership has had a successful first year of operation, fully embracing the “assembly model” which was constructed during the design period ahead of the Health and Care Act (2022) being implemented.

Building on our engagement with our partners, our local task and finish group have designed 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 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 population’s needs and the successful operation of the ICS ahead of any sector or organisation specific areas of focus

Provide a forum for the 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

Frimley ICP creates a platform for its entire membership. Local Authorities, NHS, Healthwatch, Voluntary, Charity and Social Enterprise (VCSE) organisations have formed an ‘assembly’. The assembly ensures a voice for those who can speak on behalf of their communities and bring a very new approach to the design of our strategic ambitions. The ICP works closely with partner organisations to ensure all voices are heard in planning and prioritisation decisions.

Now that the ICP worked together to refresh the five year system strategy it will now focus on organising itself to deliver the six system ambitions over the next five years. At its May 2023 Assembly meeting it will focus on the key priorities for the coming year.

Frimley Health and Care

Our People

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

14. Workforce – Strategic Context (1)

Workforce challenges in health and social care have been broadcasted for years, but the scale of change in the last two years has 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. For our system people strategy, we need to be clear where we best deliver through a system focus – where we can be stronger together to resolve some of our most difficult and longstanding workforce challenges.

The aim is to develop a people strategy based on three core priorities; these are our ambitions. These will underpin our strategy and will be focused on actions that:

- **Would best be delivered at a system level**
- **Are within the system's control**
- **Are aligned to the overarching system ambitions**

Working together to tackle some of our greatest workforce challenges

Our system workforce strategy guiding principles

We want to be known as a great place to live, work, develop and make a positive difference

We want all of our people to have the opportunity to be physically and mentally health, fulfilled, effective and flexible in how they work and what they do

We want to attract and retain our local population to careers in our health and social care system

14. Workforce - Strategic Context (2)

Local Authority

Surrey County Council
Surrey Heath Borough Council
Hart District Council
Hampshire County Council
Royal Borough of Windsor & Maidenhead
Slough Borough Council
Rushmoor Borough Council
Waverley Borough Council
Bracknell Forest Council

Independent Providers

65 CQC regulated establishments in Windsor and Maidenhead
62 CQC regulated establishments in Slough
35 CQC regulated establishments in Bracknell Forest
698 CQC regulated establishments in Surrey*
776 CQC regulated establishments in Hampshire*

Primary Care

15 Primary Care Networks
66 General Practices

*Frimley ICS boundaries do not encompass entire region.

Frimley Health and Care

Headcount: **4,733**
December 2022

Headcount: **354**
March 2023

NHS Frimley

NHS Berkshire Healthcare NHS Foundation Trust

Independent Providers

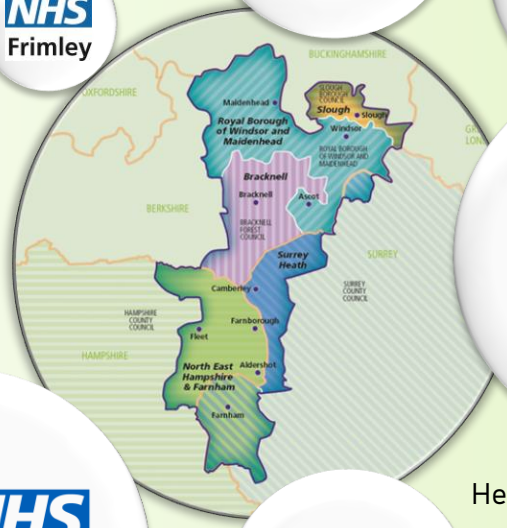
Headcount: approx. **14,500**
March 2022

Local Authority

Headcount: approx. **1,000**
September 2021

Primary Care

Headcount: **2,335**
January 2023



Adult Social Care

Headcount: approx. **15,500**

NHS Frimley Health NHS Foundation Trust

Headcount: **12,244**
December 2022

NHS Surrey and Borders Partnership NHS Foundation Trust

Headcount: **2,883**
December 2022

Total Headcount
approx. **38,000+**
(excluding bank)

14. Workforce – Key Challenges

Workforce Supply and Retention
Health and social care workforce shortages are the biggest challenge facing the NHS and social care in England. This issue has been exacerbated by the pandemic, which has exposed the dangers of running a system with significant shortages. Looking further ahead, we recognise we have an ageing workforce and an increasing turnover of people within adult social care. We need to attract and retain more people to join and stay with us, ensuring they are healthy and working within flexible, developmental, and empowering cultures

Lack of diversity amongst our workforce
At all levels to ensure care is planned, evaluated and delivered to meet the needs of everyone. In particular, disproportionate numbers of staff within the NHS from minority backgrounds face discrimination and challenges that are hampering their ability to enter and stay in the workforce and meet their full potential

Cost of living and financial challenges
Over 1.3 million staff work in the NHS and 1.8 million in social care. Prior to the current cost of living crisis it was know that in-work poverty affecting one in eight workers. We know that the rising cost of living is at the top of the agenda for our Health and care leaders and that this is set within a context of increasing public sector finance challenges and a need for increased productivity.

Lack of parity amongst our workforce
The disparity between health and social care workforce, which unless addressed and mitigated, will be a major barrier in growing the social care workforce and encouraging integration or closer working between the two sectors. The pandemic further reinforced the lack of parity between our NHS and social care workforce as our social care workforce cared for the most vulnerable people in our communities at the most challenging time. They did this while often not receiving the living wage, without access to occupational sick pay or wellbeing support. Our colleagues working in primary care and the voluntary sector were often in a similar situation.

Changing the way we work
How to equip staff and NHS frontline organisations to provide 21st century healthcare including the need to join up health and care and take advantage of digital technology, genomics and other innovations. Supporting our staff to work in partnership ac es, to increase their agility and to create new roles which better meets the needs of our communities.

Our refreshed system workforce ambitions 2023 -2025

Ambition	Outcome	Early steps
Ambition one Creating a joint workforce model for health and social care SRO: Shella Smith Surrey County Council	To create a joint health and social care career model for target roles to support greater agility in the system, enabling the workforce to be in the right place at the right time to meet health and care needs.	1. Develop new roles which meet demand gaps and strengthen health and care career alignment 2. Research options to enhance collaboration on pay, terms/conditions
Ambition two Widening access to employment and keeping the people we have SRO: Matt Joint, Frimley Health	The Frimley system is able to attract and retain the workforce it needs to deliver high quality care, leading to a more stable and satisfied workforce which is representative of its communities.	1. Pilot the introduction of community 'employment brokers' and spread this through an Anchor Institutions approach 2. Agree our system priority initiatives for attraction and retention
Ambition three Optimising all that the Frimley system has to offer to improve the health and wellbeing of our people SRO: Jane Nicholson, Berkshire Health	To create a healthier, happier and more productive workforce through investing in the health and wellbeing of our people.	1. Strengthening alignment with the system public health programme to develop a prevention approach to health management 2. Agree system priority initiatives for health and wellbeing to make the greatest contribution to strengthening workforce capacity
Ambition four Increasing the productivity of our people through delivery of our System Temporary Staffing Programme SRO: Caroline Corrigan, Frimley ICB	To ensure best use of public money through ensuring an efficient and effective temporary workforce.	1. To deliver our temporary staffing programme and ensure best practice is shared at national and regional levels. 2. To optimise benefits from all elements of the programme.

14. Workforce – Dependencies, Enablers, and Risks to Delivery

Key dependencies and enablers

Transformation and Digital

- QI methodology/Logic modelling to ensure we have clear outcomes and can evidence improvements
- Digital – aligning our strategies and agreeing shared priorities
- Aligning our workforce plans and new role ideas with transformed models of care

Finance

- Sharing plans and creating opportunities to increase productivity and take a longer term approach to our workforce terms and conditions and workforce modelling

Leadership and cultures

- Improving partnership working and creating a more agile workforce
- To provide communications and engagement support to our system workforce programmes

Equality, Diversity and Inclusion

- Ensuring Equality, Diversity, Inclusion and compassionate is at the forefront of all that we do

Public Health and clinical services

- Aligning our public health/prevention and workforce agendas
- Engaging our clinical service leads to prioritise the provision of services to our People

Workforce, education and development leaders across the Frimley Health and Care system

- To continue to develop, own and advocate for a ‘one workforce’ approach across all parts of our system

Key risks

- Not being clear about our outcomes and how we will measure impact – being able to evidence what works
- Trying to do too much – moving away from our focus areas (often due to unrelated funding opportunities or current operational demands)
- Short term funding for longer term programmes

14. Workforce – Our Priorities for 2023/24

Ambition 1
Creating a joint workforce model for health and care

- Create a joint health and social care career model and enabling structure to support greater agility in the system.
- Enabling the workforce to be in the right place at the right time and to support them to live well

First steps:
1. Develop new roles which meet demand gaps and strengthen health and care career alignment
2. Research options available to enhance collaboration on pay, terms and conditions

Ambition 2
Widening access to employment and keeping the people we have

- Identifying what works well to retain our people and support them to be their best
- Engage with our communities through an anchor institution approach to widen pathways into satisfying, valuable work.

First steps:
1. To pilot the introduction of community 'employment brokers' and spread this approach
2. To deliver our system programmes in EDI, Retention, Health and Wellbeing, Nurse/AHP transformation, Housing, Reservists and Widening participation

Ambition 3
Strengthening partnership working and new models of care

- Develop new and digitised workforce models to increase collaboration, productivity and align these to new models of care

First steps:
1. Strengthen alignment with the system digital transformation programme
2. Extending our Temporary staffing and CLEAR programmes
3. Develop a logic model approach to prioritisation and development

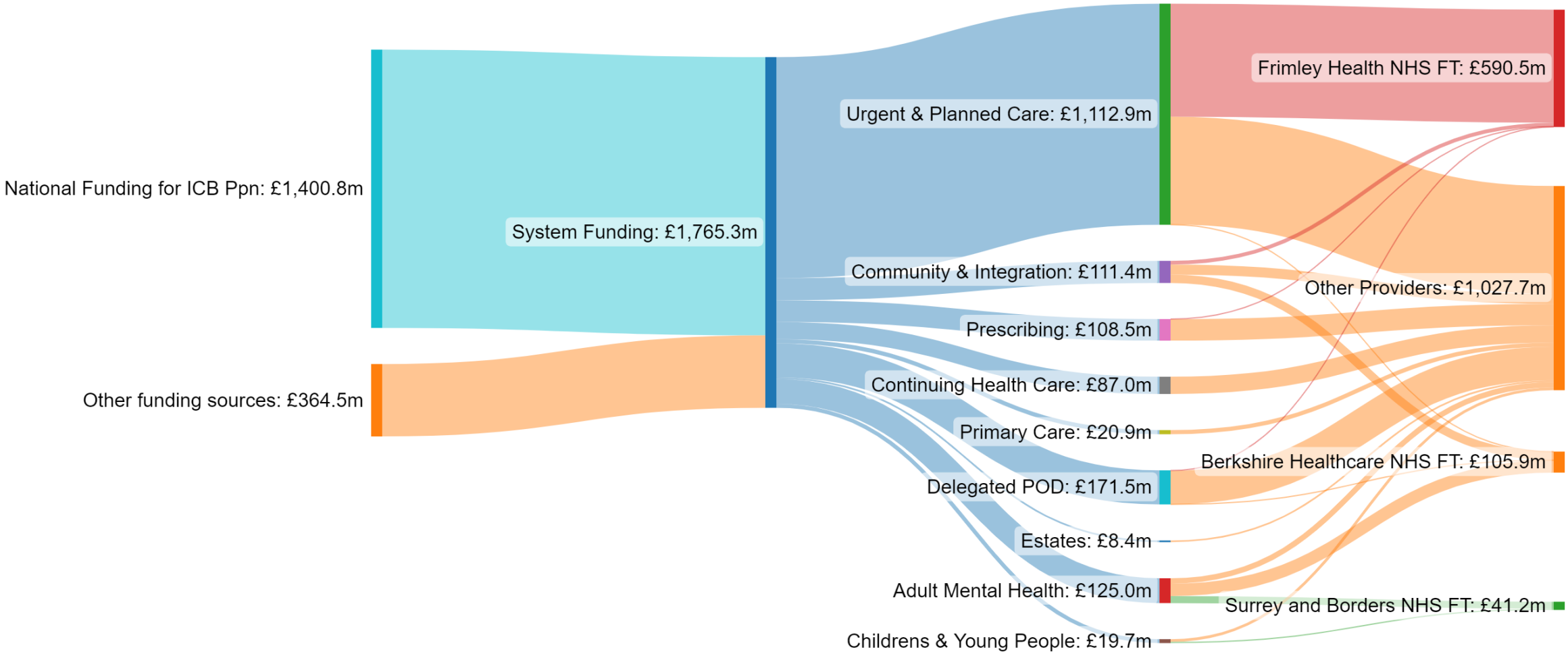
Using QI methodology we are collaboratively designing our outcomes, action plans and evaluation for each ambition, to be validated at our system People Board in May 2023

Frimley Health and Care

Our Resources

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

Our Resources - £1.8bn To Support the Needs of Our Population and Those in Neighbouring Systems



Long term financial forecast – summary and context

Health Care Perspective

- As a system we estimate that we have an underlying deficit in excess of £151m that is being supported by short term saving opportunities or additional non-recurrent national funding
- Through the System Financial Sustainability plan we know that we need to reduce costs within our system to bring us back to a break-even position
- Key to this will be understanding the total value of services offered so that our resources are prioritised appropriately
- Furthermore, assuming inflation over the period is matched by national funding uplifts, we estimate that our changing population will increase costs by 3% per annum
- This is estimated at an efficiency programme in excess of the underlying deficit of c.£55m per annum and we need to focus on delivering our preventative transformation activities to support mitigating these costs in future years.

23/24 NHS System Financial Plan

May 2023 submission

£'m		% Cost Base	% Allocation
Gross Deficit	**(146.6)**	**7.6%**	**10.1%**
Profit on disposal	16.7		
Non-Recurrent efficiencies - Surge	11.0		
Other Balance sheet/NR benefits	19.8		
Revised deficit after NR / technical adjs	**(99.1)**	**5.1%**	**6.8%**
FHFT Led	25.2		
ICB Led	11.4		
Low & Medium Risk schemes	**36.6**	**1.9%**	**2.5%**
FHFT	22.8		
ICB	6.0		
High risk efficiency	**28.8**	**1.5%**	**2.0%**
System Stretch	**33.8**	**1.8%**	**2.3%**

- The 23/24 gross deficit is £147m, 10% of the system allocation. The profit on disposal and the benefit of 22/23 non recurrent items has reduced this deficit to £99m, 6.8%. It is assumed that the change in accounting treatment for disposals will continue to apply in 23/24 allowing the profit to be recognised in year.
- Efficiency plans for FHFT and the ICB have been identified totalling £65.4m, of which £36.6m are considered to be low to medium risk. The remaining £38.8m is higher risk schemes in terms of delivery.
- In order to achieve a balanced plan a further system stretch of £33.8m has been included.
- Note that a 1.1% efficiency is assumed across all portfolios through the national tariff efficiency assumptions.
- The May submission was a balanced plan for 23/24

Our Approach to Improving Efficiency

Allocative

(1) Managing Demand for Health Interventions

Technical

(2) Efficient Delivery of Health Intervention

Technical

(3) Organisational Internal Efficiency

Technical and Allocative

(4) Efficiency in Health Procurement

Allocative

(5) System Financial Opportunities

- Aligned strategy focussed on **cost containment** and **reduction**
- Managing and/or mitigating growth to ensure flow of income growth for deficit reduction
- Financial sustainability to provide **defined services** and **capacity** to meet patient need
- Utilising a system-first approach to transforming services for the benefit of our population, regardless of organisational boundaries
- Focus on providing defined services and capacity to meet patient needs. Partners will **not** engage in activities that aim primarily to **transfer costs**
- **Trust, transparency, and data sharing** to work efficiently and effectively

Financial Sustainability Plan on a Page

Strategic Context

As an NHS Partnership, we have agreed a collective approach to how we are going to work together to deliver a financially sustainable NHS for the Frimley population. Our Financial Sustainability Plan sets out a proposed “blueprint” for the development as a system team of a programme that will deliver financial control and alignment with cost efficiency programmes for each Statutory NHS Organisation within the Frimley system.

2023/24 represents year one of a multi-year system financial sustainability plan, to support delivery of the strategic objectives of the Frimley Integrated Care System. The intention is that the blueprint aligns with and complements the developing system governance architecture, such that the objective of delivering a financial “sustainability”, as opposed to “recovery” programme can be delivered. The programme is not intended to be a one-off recovery intervention, but a sustainable solution which enables the system to maintain recurrent financial grip and optimise value-based decision making on an ongoing basis.

The choice of terminology in describing the programme as system sustainability rather than “turnaround” or “recovery” is deliberate. The intention is to develop a programme which can sit within the system’s business as usual governance structures in order to establish and to retain a financial sustainability mechanism to place the system on a secure footing to deliver future strategy.

The sustainability programme must focus on the clear understanding and effective control of the system cost base as a single system entity, rather than an aggregation of organisational positions; such that the system is able clearly to consider and to account for inter-dependencies between different options for the deployment of financial resource to meet health need, in order to inform optimal decision making.

High level financial modelling identifies a material underlying gap in resource availability. The system will adopt an approach to planning on the basis of demand, and capacity to meet that demand, which will enable that financial resource gap to be described alongside a capacity resource gap, with a clear relationship between the two gaps.

Our Financial Sustainability Principles

1. Prioritisation of NHS resource allocation, based on clinical and cost effectiveness – focusing on those which are the most effective

2. The development of New Care Models – developing new ways of working across the health, social care and voluntary sectors.

3. Optimising Value for Money - continue to review all services to optimise value for money, reduce duplication and free up resources to respond to population growth and increasing demand

4. Maximisation of Technical Efficiencies

5. Reduction in Unwarranted clinical variation

6. All efficiency schemes must include a clear route to monetisation for the Frimley system. Plans will:
    a. Include schemes which create capacity being utilised to repatriate or to facilitate reductions in escalation capacity and will take account of stranded costs and consequent time to monetisation.
    b. Allow for cases which need to be combined to release fixed or semi-fixed cost to be progressed together, without which monetisation cannot be delivered.

7. System development and maintenance of a clear understanding of its cost base in order to:
    a. Allow comparative analysis of alternative options to meet demand. For example, new community services vs. meeting the same need in an acute setting, avoiding step costs for new facilities or the opening of escalation capacity if the same need can be met in an alternative setting).
    b. Give visibility of fixed and semi-fixed costs in order, for example, to realise estates opportunities, and to allow the development of benchmarking internally and with others.

FHFT - Our Capital Plan for 2023/24

Frimley Health Foundation Trust 23/24 Capital plan

Capital Scheme	Scheme category	DHSC Programme	Type	Method	23/24 plan £'000
HWD Estate	Backlog Maintenance - Moderate and low risk	Non Central Programme	Owned	Internally Funded	250
WP Estate	Backlog Maintenance - Moderate and low risk	Non Central Programme	Owned	Internally Funded	8,083
FP Estate	Backlog Maintenance - Moderate and low risk	Non Central Programme	Owned	Internally Funded	3,000
RAAC Failsafes (PDC)	Backlog Maintenance - Significant and high risk	RAAC Plank	Owned	PDC	5,000
FP Estate - M Block Development (TIF)	New Build - Multiple areas/ Other	Elective Recovery/Targeted Investment Fund	Owned	PDC	0
FP Estate - M Block Development (Trust)	New Build - Multiple areas/ Other	Non Central Programme	Owned	Internally Funded	12,175
Satellite sites Estate	Backlog Maintenance - Moderate and low risk	Non Central Programme	Owned	Internally Funded	750
Digital Services Strategy	IT - Other	Non Central Programme	Owned	Internally Funded	5,000
Medical Equipment	Equipment - clinical Other	Non Central Programme	Owned	Internally Funded	5,000
Total Allocation 23/24					**39,258**

ICB - Our Capital Plan for 2023/24

ICB 23/24 Capital Plan

Capital Scheme	Scheme Name	Capital Acquisition / Capital Grant	Capital Type	23/24 plan £'000
GPIT BAU	Replacement, refresh, fix programme	Acquisition	GPIT	500
MIG schemes	Increasing clinical and admin capacity, improving access and infection control	Grant	Improvement Grant	312
GPIT Future infrastructure	To bring the NEHF and SH practices onto GPNET the system used by the EB practices	Acquisition	GPIT	200
N365 Licences	Refresh of N365 licences for both GPIT and corporate access	Acquisition	GPIT	175
MIG schemes reserve	Increasing clinical and admin capacity, improving access and infection control	Grant	Improvement Grant	49
Total Allocation 23/24				**1,236**
Note: also included in the plan for additional funding				
IFRS16	Sandhurst leases	IFRS16	New Lease	1,739

Our Shared Estates Strategy

- Achieve a safe, clean, secure, complaint fit for purpose estate and a progressive exist from poor quality and poorly utilised estates.
- Enable the delivery of ICS clinical strategies and new models of care.
- Enhance patient experience by creating welcoming and comfortable environments for patients, families
- Meet regulatory requirements for environmental sustainability, ensuring focus on the drive toward NHS net zero carbon goals
- Design facilities to support the delivery of care in cost effective and timely manner across ICS organisations.
- Standardise technology so that multi-providers can effectively work within any building/facility for example to support care closer to home principles including access to results, near patient testing, and diagnostics
- Unlock efficiencies through the improved utilisation of all the existing estate across all the organisations in the ICS and implement the recommendations following the reports by Sir Robert Naylor and Lord Carter in relation to the NHS Estate.
- Reduce the burden of backlog maintenance and critical infrastructure risks

New Hospital Programme – Frimley Park Hospital

Frimley Heath NHS Foundation Trust (FHFT) has been granted funding for the development of a new, state-of-the-art hospital for Frimley Park Hospital through the Government's New Hospital Programme. This new hospital will provide the modern and efficient environment for the patients and staff of FHFT and our wider system.

The trust's clinical teams and advisers have recommended that a new site should be found for the new hospital to avoid the significant disruption to patients, services and staff that would be inevitable if an attempt was made to redevelop the current site. This would require a phased demolition and rebuild over many years on a site which is already overly congested. Work on this will start in immediately in and will progress through 2023-24 and beyond.

FHFT will also embark on a significant communication and engagement programme so that our patients, staff, volunteers, the local community and other stakeholders will be involved and engaged in all stages of the new hospital development. The input and views of all of our stakeholders will play a key part in shaping the new hospital and updates will be provided regularly.

The new hospital will enable the transformation of services for patients and the local community – it will significantly improve patient care, experience and outcomes within an ultra-modern environment for the benefit of patients, visitors and staff including:

- a significantly increased proportion of single en-suite rooms and more beds in a much-improved environment to better meet the needs of the local population
- improved and extended facilities that will enable more patients to be diagnosed and treated in the same visit
- more state-of-the-art operating theatres to treat more patients
- smart use of the latest digital technology and IT infrastructure to greatly improve the experience of patients and staff
- a host of environmental benefits including improved energy efficiency and sustainability
- the latest designs and best practice for infection control
- carefully considered co-location of services within the building which will greatly improve patient and visitor movement, and group staff together to enable better clinical outcomes and team working
- exciting opportunities to increase the integration of primary and community care with hospital and secondary care across the wider Frimley Health system to better serve patients

Ultimately, the new development will clearly align with our longer-term strategies and plans. It will allow us to develop our estate and services to ensure that they best suit the communities we serve and are fit for the future of healthcare.

Procurement and supply chain

Frimley ICS includes two procurement bodies – Frimley Healthcare and Frimley ICB. Frimley Healthcare as a provider Trust is responsible for clinical procurements of goods and services including category, supply chain and materials management in line with the terms of the Trust's Procurement Policy and work plan. Frimley ICB as a healthcare services commissioner is responsible for contracting for a wide range of healthcare services. The procurement services is provided by SCWCSU in line with the ICB's Procurement Policy and relevant legislation.

Both organisations share a vision for the ICS to deliver high quality services for patients at the best value for the system and will actively look for opportunities to collaborate to achieve this goal.

The organisational change to Integrated Care Boards (ICBs), phased delegation of direct commissioning and elements of specialised commissioning, and the emerging role of provider collaboratives need to be considered from a procurement perspective. In addition there is the proposed removal of the competition requirements in the Health and Social Care Act, withdrawal of healthcare services from the Public Contracts Regulations 2015 and the introduction of a Provider Selection Regime (PSR).

There will be various ways to secure healthcare services contracts as the PSR is intended to provide ICBs greater freedom and flexibility to deliver integrated services, locally. Once the regime is legislated we will still be required to evidence robustness decision making alongside understanding the opportunities within the new regulations to identify the most appropriate route to secure the best providers for services – this will include a streamlined provider and service assessments process alongside more traditional competitive processes. The PSR will provide a number of different procurement routes depending on the current contractual arrangements and market situation.

The ICS will review the options available once legislation is passed and introduce system wide processes and governance arrangements to ensure that the most appropriate Decision Circumstance is adopted when procurements are undertaken. The procurement strategy will need to support the wider ICS five year forward vision. It will identify priorities of activities and provide timescales of delivery, and will need to include a clear position of when the procurement function will be fully operational within the ICS.

Close working relationships with partners and also collaboration with other organisations brings economies of scale, sharing of data and best practice so that the system maximises savings and efficiencies.

Procurement and supply chain

Strategic Context

Supply Chain Challenges

- Global supply problems
- Supplier instability
- High inflation leading to increase product and service costs
- Increased fuel and energy costs
- Recruitment and retention difficulties

NHS Commercial Considerations

- Consolidation of procurement service provision and contracts
- Increasingly centralised approach to NHS contracting and category strategies
- Standardised approach to data and system provision
- Need to focus on NHS' impact on the environment and society
- Change in Procurement legislation around the commissioning of health services

Procurement and supply chain

Looking ahead

Area of focus	Key Action Areas	Benefits and outcomes	Timeframe
Our people	1. Continued professional development (CIPS) of Procurement staff 2. Embed Frimley Excellence improvement system within Procurement service	Greater capability of staff, job satisfaction and improved service delivery leading to greater financial efficiency and staff retention.	1. Within 12 months 2. Within 12 months
Our partners	1. Consolidate Procurement service provision within the ICS 2. Collaborate on relevant contract opportunities between ICS partners	Improved financial efficiency, service resilience and alignment with national strategy	1. Within 24 months 2. Within 12 months
Our data and systems	1. Upgrade of FHFT e-finance/procurement system 2. Expansion of inventory management system within FHFT 3. Implement national workplan and e-sourcing system (Atamis)	Greater financial control, improved stock management, improved efficiency and alignment with national strategy	1. Within 12 months 2. Within 24 months 3. Within 12 months
Our processes	1. Update Trust Procurement policy 2. Implement formal contract management approach within central Procurement 3. Introduce Procurement training for budget holders	Improving our impact on society and the environment, financial efficiencies, promoting a culture of financial prudence and improved service delivery from our suppliers	1. Within 12 months 2. Within 12 months 3. Within 12 months

Climate Change, the Green Agenda, and Net Zero

Our focus in taking forward our strategic objectives

Our strategic ambition and objectives capture the magnitude of the transformation which the Trust will undertake, although the phasing of activity may not be uniform across our ambitions and objectives. The focus in implementing our Green plan will comprise of three distinct phases.

2022-2025

Phase 1: Making net-zero everybody's business

- ✓ Continue to drive incremental improvements in our directly controlled carbon emissions
- ✓ Integrate sustainability into ongoing major projects
- ✓ Prepare Frimley Health for fundamental change through capability & capacity building
- ✓ Make sustainability 'the norm' alongside care quality and finance

2025-2030

Phase 2: Accelerating and Broadening impact

- ✓ Accelerate performance improvements identified throughout the enabling phase
- ✓ Publicise success widely and engage in cross-sector and regional best practice knowledge exchange
- ✓ Establish detailed roadmap to 2040 and 2045
- ✓ Monitor for innovation and disruptive technology that enable the Trust to go further

2030-2045

Phase 3: Capitalising on our net-zero ambition and pushing the boundaries

- ✓ Sustainability becomes a driver of corporate strategy
- ✓ Strategy firmly linked to delivering improvements in health inequalities and other ICS health priorities
- ✓ Lead wider societal change through our anchor organisation status

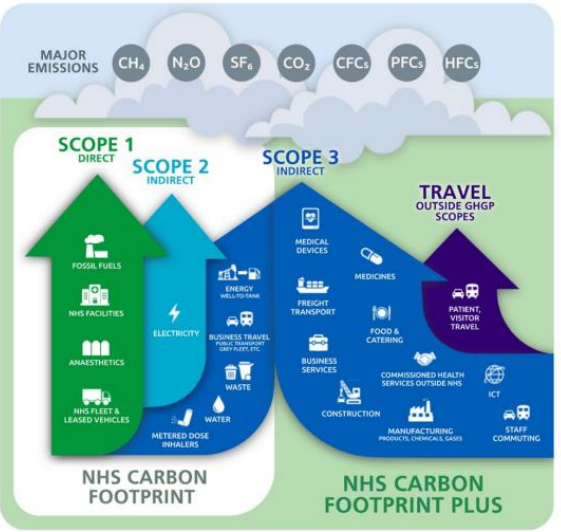
How we will deliver our strategic ambitions

The first phase of the Green Plan's implementation seeks to **make our net-zero carbon ambition everybody's business**, and all Frimley Health staff will have a role to play. We recognise that colleagues are primarily focused on the demands of their respective clinical or non-clinical roles and that simply adding sustainability to those existing priorities may be ineffective in driving organisational change.

Our delivery of the Green Plan will therefore adopt an approach of enabling, in which management teams across the Trust provide the cross-cutting capabilities, understanding and support for colleagues to make sustainable practice. The focus on enabling change will be supported by ongoing communications and education that will raise awareness so that they are empowered to make choices that deliver decarbonisation across our organisation, with some exemplar themes illustrated below.

Continuous Improvement	Digital	Estates & Facilities	Supply Chain
Recording success & sharing knowledge	Platforms to enable low carbon working modes	Providing access to low carbon workspaces	Enabling our staff to access low carbon goods and services

Informed Frimley Health colleagues implementing the Green Plan as a part of their daily priorities



- ✓ to achieve net-zero by 2040 for the NHS Carbon Footprint (directly controlled emissions); and,
- ✓ to achieve net-zero by 2045 for the NHS Carbon Footprint Plus (indirectly controlled emissions).

Green Plan 2022-2025 "Making Carbon net-zero everybody's business everyday"

PowerPoint Presentation (fhft.nhs.uk)

Research and Innovation

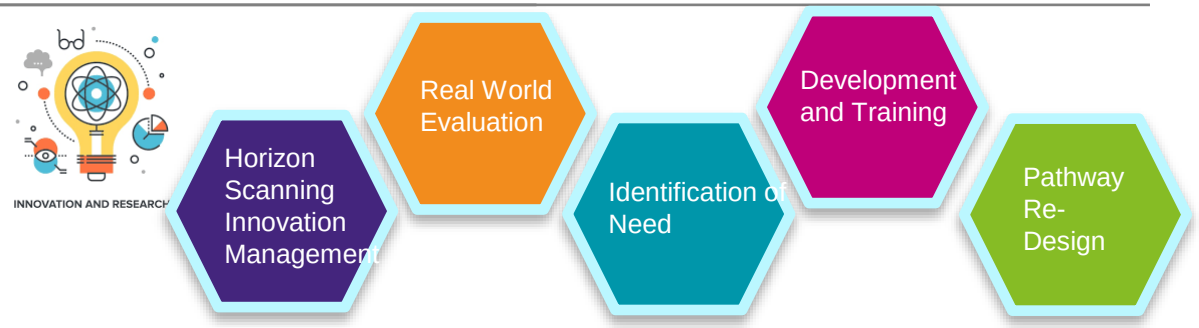
Creating a Culture of Learning Research and Innovation

Research and innovation play an active role in informing and enabling the system to prove value and achieve transformation through data driven evidence to address health inequalities and ensure sustainability.

Across Frimley Health and Care ICS we want to collaborate with Industry, Academia, and Health and Care to strengthen our involvement in, and benefit from, research and innovation. Bridging the gap between new knowledge, research and implementing evidence of what works to improve the outcomes for our population.

We want to create the conditions for quality improvement to create a high learning health and care system, where best practice is shared confidently and adopted quickly across our communities, places, and Frimley to improve patient outcomes, safety and experience.

- Improve the quality of health and care and outcomes for all through the evidence generated by research.
- Increase the breadth of research undertaken locally addressing local priorities.
- Encourage research and innovation across the partnerships within the system including primary care, mental health services, public health and social care
- Drive the use of research evidence for quality improvement and evidence-based practice.
- Harness the patient and economic benefits of commercial contract research.



Working in collaboration with our Academic Health Science Network (AHSN), Frimley Health and Care ICS will:

- Collaborate with the AHSN on horizon scanning, real world evaluation and spread and adoption of innovation.
- Explore evidence-based innovation in collaboration with the AHSN and the ARC to support our health priorities aligned to CORE20Plus5.
- Engage and explore Innovation in Industry in collaboration with the AHSN.
- Address inequity of access to innovation including delivering the ICS Innovation for Health Inequalities programme focusing on COPD.
- Focus on CVD, CYP MH and long term respiratory illness
- Improve Patient safety in maternity, medicines, and care homes through the AHSN's Patient Safety Collaborative.
- Build stronger links to the research community so that Frimley's population will benefit from participating in research trials and our providers are participating in research.
- Share learning across neighbouring ICS to speed up adoption of innovation.

Costed Digital Plan - The Principles that Guide our Digital Choices

1. All Digital initiatives will improve or at least maintain **Quality of Care and Clinical safety**
2. Digital and non-digital access channels will provide the same functionality, thus **ensuring inclusivity and digital equality**.
3. Digital solutions will be **co-designed with stakeholders** to ensure they are fit for purpose, intuitive and flexible, making it easy to do the right thing
4. Employees and **Residents will be consulted to inform and enhance the design and functionality** of our digital services.
5. Change Management techniques will integrate Digital Solutions into clinical and management practices such that they at least meet their requirements
6. Employees and residents will be **enabled and empowered to use digital resources effectively** - our staff will have access to the training, guidance and support they need to use digital resources as we optimise them through building a culture of knowledge sharing and continuous learning.
7. Equal access to digital resources for all – **our citizens will have access to a collection of resource libraries across the ICS** alongside the training material. We will utilise the voluntary sector to ensure equality and inclusion.
8. Cost effective services – we will **deliver value for money services that are efficient, financially sustainable** and enable our Partners to provider higher quality Health and Care services more cost effectively.
9. Employees and Residents with **the highest needs will be prioritised**, such that all digital resources will be focused on delivering maximum possible impact.

Costed Digital Plan – Foundational Infrastructure

1 Foundational Infrastructure

Leveraging and harmonising our Digital Assets

1. **Use Digital to improve care**
2. **Leverage and harmonise our Digital assets**
3. **Enable collaboration and seamless flexible working**
4. **Continue to improve our Infrastructure; performance and security**
5. **Converge to common hardware, software and processes**
6. **Re-engineer commercial and procurement capabilities**

Initiatives

1. **Optimise our existing Digital assets,** through the continuous improvement of our core systems.
2. **Extend virtual care model into other services and specialities**, learn from our remote monitoring pilot to enable patients to be more independent and to better engage and manage their own care needs.
3. **Create a resident centric collaboration tool** for all Health and Care professionals and Multi-disciplinary teams, to optimise cross partner collaborative and enabling true joint integrated care decision making and planning.
4. **Support Innovation and pilot innovative digital solutions** to increase capacity and release more time for patient care, including Robotic Process Automation of clinical and operational administrative tasks.
5. **Create communities of expertise**, to establish common standards and processes, and to pool scarce expertise. For example: Architecture, Analytics, Cyber Security, Data Communications, Integration and Networking.
6. **Align infrastructure technology objectives** across providers and **deliver infrastructure improvements**, including single sign on, convergence to common hardware and software convergence, upgrading end-user devices and secure performant network infrastructure.
7. **Deliver cost effective IT Service Delivery and Support capabilities**, implementing improvements, such as self-service, and identifying opportunities to realise synergies through contract rationalisation and/or service redesign.

Outcomes

These Initiatives will improve the care we provide to our residents, by:

- Improving the core systems used by our staff.
- Converging digital solutions, technologies and processes; making it easier for our staff to work across Providers and reducing practice variation.
- Enabling our staff to have greater flexibility to work anywhere and be able to securely and seamlessly connect to the systems they use.
- Making it easier for our staff to collaboration across providers and provide integrated care services.
- Facilitating faster and more responsive integrated services by providing the right information to the right person at the right time.
- Realising cost savings from convergence, simplified commercial and procurement processes, and better vendor management.
- Releasing time for resident care through productivity efficiencies arising from convergence, process standardisation, and collaborative working.
- Accelerating the adoption of new digital solutions, ways of working and innovation through common infrastructure and greater collaborative working.

Costed Digital Plan – Sharing and Using Our Information

2

Sharing and Using our Information

Informing joint integrated care decisions

1. **Enhance our Connected Care shared care record**
2. **Broaden the use of our Connected Care shared care record**
3. **Improve the sharing of information across Providers and enable seamless transfers of care**
4. **Implement a shared centralised technical architecture**
5. **Level up our BI capability across providers**
6. **Increase the use of data and information for clinical, operational and strategic decision making**
7. **Digital Diagnostics and Image Management Networking**

Initiatives

1. **Enhance our shared care record**, Connected Care, by building upon its current capabilities and embedding additional datasets from across the wider ICB (for example Courts, Police and Education).
2. **Broaden the use of our shared care record**, Connected Care, by making it easier to access from our core systems, promoting its benefits, extending its usage to wider ICB partners (Courts, Police and Education), and providing training opportunities.
3. **Improve the sharing of health and care plans** between all partners and our residents, prioritising according to need and considering closed loop notification of events (requests, acknowledgements and appointments).
4. **Enable seamless transfers of care**, by creating and sharing consolidated datasets at points of transfer, including progressive nursing information, progress notes and social care information.
5. **Implement a single data warehouse infrastructure and reporting tool** to extract true insights from our data and improve care.
6. **Increase the use of data for clinical, operational, and strategic decision making**, through adopting clinical decision support, and operational dashboards.
7. **Improve systems interoperability** between partner systems through adherence to agree open systems architecture standards and data management standards to enable easier direct integration and data sharing.

Outcomes

These Initiatives will improve the care we provide to our residents, by:

- Sharing information across organisations and disciplines and enabling collaborative working
- Accelerating health and care decision making and planning
- Reducing delayed admissions and discharges through seamless transfers of care and sharing of information
- Improving multi-disciplinary care by enhancing access and sharing of real time information
- Optimising the use of our shared care record, Connected Care, and using data to inform care
- Greater user satisfaction from continuously improving Connected Care, making Connected Care the main source of patient information
- Implementation of a shared technical architecture (Target Data Architecture), including use of open standards, to drive integration and sharing of information

Costed Digital Plan – Empower our Employees and Residents

3

Empower our Employees and Residents

Putting people first

1. **Empower our Residents to be at the centre of their care**
2. **Support Digital Equality and Inclusion**
3. **Empower our Workforce to drive the digitisation of services and convergence of systems**
4. **Advance the digital competency of our Workforce and Residents**
5. **Adopt Common training materials and trusted HR policies across ICS partners**

Initiatives

- **Implementation of Patient accessible record/s and consolidation of access points** via the NHS app, enabling our Residents to better interact and manage their Health and Care plans.
- **Establish a Digital Academy** to advance the digital competency of our People and our Residents, and lead the professionalisation of our Digital Workforce.
- **Establish internal and external Digital Champions Networks** to encourage use of Digital, Digital Equality and Digital Inclusion**.** Main priorities to include marketing of Digital solutions, providing support, and device libraries.
- **Publish and deliver on a Digital Communications Strategy**, including enhancing our social media presence and promoting use of Digital solutions.
- **Expand use of Digital solutions that support Residents** to manage their own health and care. Main priorities to include Digital self-care technologies, virtual consultations, and virtual ward technologies.
- **Continue to digitise working practises and processes**, focusing on releasing time to care, and converging systems where appropriate.
- **Create 'one system workforce' collaboration solutions** to include a unified Service Directory that acts as the single point of access for Employees and Residents, record sharing, tasking and joint care planning.
- **Establish trusted and integrated HR policies for recruitment, retention and training.** Main priorities include converging training systems to alleviate unnecessary 'repeat' training.

Outcomes

These Initiatives will improve the care we provide to our residents, by:

- Empowering Residents to be at the centre of their care and to undertake greater self-management.
- Facilitating joined-up care delivery by providing access to more comprehensive and holistic Personal Health Records.
- Enhancing data security and information governance to keep Resident information safe and secure.
- More effective sharing of our People across Providers through Shared training records, Digital ID passports and a Common Directory.
- Tackling digital exclusion and digital inequality to prevent socially deprived or hard-to-reach groups experiencing a double disadvantage.
- Raising the digital competency of our People and releasing more time to care for our Residents.
- Increasing the efficiency of administrative tasks and increasing the use of Digital to support care.
- Improving the quality of care and providing greater service capacity to allow for more Residents to be cared for and improving their experience.

Costed Digital Plan – Population Health Management

4

Population Health Management

Data driven, digitally enabled care

- **Expand data inputs and proactive capabilities**
- **Move towards a single shared Analytics platform**
- **Optimise our use of data for provision of care**

Initiatives

1. Extend Connected Care to be an insight driven proactive decision making tool
2. Improving user experience, front end design and user support to help increase uptake and adoption of population health tools
3. Expand available data inputs (Fire/Police/Social Care/Housing/VCSE)
4. Create a single shared technical architecture across the Provider partnership
5. Embed real time clinical decision support to support long term conditions.
6. Optimise our patient pathways based insights from PHM data
7. Facilitate MDTs for effective co-ordinated care, transfers of care and continuity of care.
8. Drive a culture of evaluation and continuous monitoring where data insights help drive and unlock improvement opportunities

Outcomes

These Initiatives will improve the care we provide to our residents, by:

- Enabling care providers to proactively identify patients where there are opportunities to improve outcomes based on analysis of their health data
- Use of population segmentation to help manage urgent demand
- Improved understanding of the needs of the population, enabling opportunities for new or improved services to be identified
- Near real time and continuous evaluation of projects to enable continuous improvement cycles and clear measurement of impact
- Establishing clear links between strategic priorities at system level, and identifying priority cohorts in our population, for example, identifying and supporting our “Core20Plus5” cohorts in order to achieve our strategic goal of reducing health inequalities
- Improved management of long term conditions and reduction in variation
- Improved effectiveness in dealing with proactive workloads in primary care

Frimley Health and Care

APPENDIX A

Year One Delivery Plan – 2023/24

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

Year One Delivery Commitments

Children and Young People – Priorities for 2023/24

Children's Mental Health - Fund and implement the psychiatric liaison team at Frimley Park Hospital
Children who are waiting for a surgical intervention
Children with Life Long Conditions - Scope provision of a psychology support service for young people with long term conditions, to reduce escalating mental health need within these services, and to address clinical psychology workforce gaps.
Children with Learning Disabilities - Address gap in provision for children with a learning disability in East Berkshire
Children in Care and at the edge of care - Reduce health inequalities faced by children in care
Children with mental health needs re. Eating Disorders - Improve monitoring of children and young people with an eating disorder.
Children with Asthma - Deliver asthma transformation plan.
Amplifying the voice of children and young people - Fully establish the Youth Board, which should include Care Leavers
Children who are Neurodiverse - Improve wait times for Autism/ADHD assessments
Children with Special Educational Needs and Disabilities - Integrated therapies
Proactive/early intervention and Self-Management - Expand use of Healthier Together app to try to divert low need/low risk children from urgent emergency care services.
Children with complex needs housing and support options - Supporting local residential provision for complex care children.
Children with continuing health care needs - Establish dynamic purchasing framework for continuing care agency packages.
Partnerships and working together with children and young people
CYP ARRS Roles
Review of Mental Health Support Teams (MHSTs) in schools

Neurodiversity – Priorities for 2023/24

- LDA Champion
- CAMHS LD service in East Berkshire
- Pre- and Post-Diagnostic Service for Autistic Adults
- Autism Diagnostic Pathway for Adults-
- Keyworker service
- PEACE (Pathway for Eating Disorders and Autism developed from Clinical Experience) pathway
- Inpatient and Community Oversight

Year One Delivery Commitments

Mental Health – Priorities for 2023/24

Changing how we support people in the community

- Community Mental Health Transformation
- Early intervention in psychosis
- IPS employment support
- Adult Eating Disorders
- Lived Experience

Urgent and Emergency Care

- Safe Haven expansion
- Crisis beds
- MH and Ambulance offer
- NHS 111 MH option
- Inpatient flow
- Out of Area Placements (OAPs)

Early support

- NHS Talking Therapies

Health Inequalities

- Physical Health Checks
- Dementia
- Neurodiversity
- Suicide Prevention
- Perinatal
- Rough Sleepers
- Section 117 Aftercare

Primary Care – Priorities for 2023/24

Access, Capacity and Demand

- Increase use of minor illness offer in community pharmacy
- Review and deliver primary care led urgent care services in the community
- Delivery of at-scale models of care, focused on improved access and support
- Establishment of the General Practice Alert System aligned to OPEL
- Implement and support the insights tool for general practice (Insights Version 2)

Digital

- Implement the front door digital offer including online consultation, video consultation and digital telephony
- Clearly define the GP IT operation model
- Maximise the opportunity through remote management opportunities from remote monitoring and recall via SMS models

Workforce

- Review and develop the ARRS workforce plan for 2023/24, including the new ARRS roles and planning ahead to new GP contract
- Deliver and develop the flexible workforce pools for GP and nursing
- Increase the number of apprenticeships in the primary care workforce
- Develop a programme of education on workforce culture, staff wellbeing and freedom to speak up

Engage with population and communities

- Co-design with our people support wider adoption of digitally enabled services approaches
- Evaluation and learn from communication with our population on the offer from general practice

Year One Delivery Commitments

Community Health Services – Priorities for 2023/24

Reduce waiting times

Increase capacity within community services

- Make every contact count, e.g. use of hubs and one stop and ensuring value adding patient care
- Moving to needs based care and support, e.g. Patient initiated follow-up where appropriate
- Increase remote monitoring
- Manage our workforce in line with recruitment and retention plans

Continuing our ongoing transformation programmes to ensure sustainable and efficient use of resources, e.g. Heart Failure; Diabetes; Intermediate care

Improve system flow

- Ensure effective use of in reach – interdependency with UCR / Frailty / Virtual Wards
- Reduction in 'lost bed days' including 'LOS'
- Increase usage of virtual ward
- Increased numbers of community beds
- Trusted assessment model
- Making every day matter

Improving access

- Self referral to key services, e.g. MSK; Hearing and balance; Falls
- Reducing unwarranted variation

Review of DATC (diagnosis and treatment centre) – prevent duplication within community/primary care settings

Agree areas of duplication that will need longer term input – e.g. Community front doors, Single Point of Access

Planned Care – Priorities for 2023/24

- Reduce avoidable referrals in dermatology, ENT, MSK, pain, gynaecology, cardiology
- Provide alternative services in cardiology, pain, ENT and MSK
- Roll out the MSK app and scope for pain
- Review current provision in Tier 2 services
- Increase capacity through additional diagnostics funding and Heatherwood Hospital elective hub
- Reduce workforce gaps through retention as well as training and recruitment
- Maximise IPS capacity
- Increase efficiency to above pre-pandemic levels
- Improve specifically theatre utilisation and day case rates to meet national targets
- Increase PIFU and reduce follow up demand
- Maximise opportunities from the MFH app
- Improve readiness for surgery using population health information and remote monitoring
- Ensure inclusive recovery through rounds of waiting list analysis and actions

Year One Delivery Commitments

Major Health Conditions – Priorities for 2023/24

Diabetes

- First year of diagnosis
- High need groups
- National Diabetes Prevention Programme
- Type 2 diabetes remission
- Peer support and resident voice
- Structured education
- Implementing NICE
- Medicines optimisation
- Podiatry
- Remote monitoring
- Reducing length of stay in hospital
- Pregnancy
- Communications

Cancer

- Prevention and screening
- Early presentation for diagnosis
- Effective and timely diagnosis and treatment
- Support for patients before, during, and after treatment

Stroke and Neurology

- Stroke prevention
- Acute and urgent care
- Rehabilitation and life after stroke
- ISDN Stroke Survivor and Carer Panel

Respiratory

- As this Joint Forward Plan is developed, we will undertake a deep dive to look at our population health data for respiratory and our urgent care opportunities to help us identify how we can be more pro-active and support those areas with greater needs.
- We will also hold a strategy session to look at what improvements we can make to our existing offer from our specialist teams.
- We have already held teaching session across the ICB at the GP education events and will continue to do this for 23/24 as well as looking at how practices in need can be better supported. We are aiming for more discussion of patients and less need to refer for an outpatient appointment.
- We will role out an LCS for spirometry and FeNO to ensure all breathless patients receive timely and accurate diagnostics and onward care they require.
- Develop a formal referral system to enable community pharmacists to refer to primary care or other organisations as appropriate.
- Develop consistent guideline for diagnosis and management of asthma including the referral pathway for severe asthma including biologics.
- Develop a way to implement targeted case finding for people with symptoms suggestive of COPD increasing our diagnosed COPD population which is below prevalence figures.
- We will also develop a breathlessness pathway to ensure patients do not bounce around the system but receive an appropriate diagnosis in a timely fashion (62 days) delivered through our CDC hubs. We will do this jointly with cardiology.
- We need to increase awareness of managing comorbidities in people with COPD providing more holistic care in particular in regard to Cardiovascular and diabetic risk developing a protocol for risk assessment and treatment

Year One Delivery Commitments

Major Health Conditions – Priorities for 2023/24 (continued)

Cardiovascular disease

- Focus on primary and prevention and management of Hypertension
- Increase the detection and management of people who have undiagnosed hypertension
- Increase access to BP testing in wider community settings
- Work with practices and PH to maximise NHS Health Checks uptake and follow up to support early diagnosis and management
- Increase support for patient self management and self testing to become routine practice
- Ensure delivery of CVD prevention DES
- Accelerating MECC interventions - action through routine outpatient appointments, antenatal care, perioperative assessments, noting that secondary prevention of CVD and should be seen as everyone's responsibility
- Working closely with Community Pharmacies and supporting uptake of BP Detection
- Scope and start to develop Frimley ICS CVD Prevention Strategy and action plan
- Workplace Health - explore staff offers of support around: Smoking, Healthy Weight and hypertension
- Health improvement campaigns across the ICS – raising awareness of CVD risk factors and opportunistic detection and develop a 12 month Communications plan
- Contributing and aligning to the CORE20PLUS5 approach
- Using Connected Care data to develop specific measures to address suboptimal management of hypertension
- Articulate opportunities of partnership and develop a tailored partnership plan to tackle hypertension in each of our 5 places – ensuring interventions embrace ethnic and cultural diversity and target communities with poorer outcomes
- Support individuals at risk of CVD to make behaviour changes: becoming more active, maintaining a healthy weight, safe levels of drinking and stopping smoking
- Develop a Frimley ICS Healthy Weights action plan
- Roll out Tobacco Dependency programme in the Acute and Maternity
- Roll out our updated lipid management pathway
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Year One Delivery Commitments

Maternity and Neonatal – Priorities for 2023/24

- Consider the Single Delivery Plan when it is published and how we organise ourselves to deliver
- Develop and support workforce initiatives
- Host a workshop for health visiting and public health leads to explore health visiting workforce challenges and potential solutions
- Develop data capture and sharing across data sources including EPIC, Operational Delivery Network, Connected Care, public health and workforce to provide a clear overview of the programme and impact
- Maximise information sharing through EPIC Care with Health Visitors and GPs
- Implement a one year comms plan for maternity
- Review existing and potential resources and capacity to support-maternity website, Solihull, Healthier Together including maternity app
- Establish our Equity Steering Group to oversee implementation of the plan
- Progress key areas within the digital strategy including connectivity
- Embed and develop maternity hubs, securing a community venue in Surrey and aligning with 'integrated care hub' programme and place leads
- Collaborate with partners on influencing diet, exercise, infant feeding, smoking and mental health.
- Support our maternity voices partnership in their work plan including diversifying their membership.
- Recruit and establish our Independent Senior Advocate
- Continue to implement :-
    - Ockenden recommendations
    - Prem 7 initiatives on pre-term birth
    - Saving Babies Lives
    - Reducing admissions of full term babies to neonatal units (ATAIN)
    - Maternal Medicines Networks

Urgent and Emergency Care – Priorities for 2023/24

- **Community Transformation** – Building additional capacity in the Community / non-acute hospital and VCSE hospices sector by using a full range of physical and virtual care alternatives
- **Proactive Management of High Risk Patients** – Supporting patients who are most at risk of hospital admission with virtual solutions to manage their condition safely out of hospital
- **Primary Care Transformation** – Creating greater access and resilience in the primary care sector to ensure the needs of residents can be met more quickly
- **ED Access** – Building new pathways and capacity to provide multi-disciplinary clinical support to reduce long waits in emergency departments
- **FHFT Improvement Plan** – Improving bed availability by reducing admissions to the core G&A bed base and improving flow through the available bed base
- **Additional Discharge Capacity** – Ensuring that those patients who are ready to leave hospital are able to move onto their next appropriate setting of care
- **Children and Young People** – Directly supporting younger age groups with the help they need to ensure their social conditions and health needs are met
- **Mental Health** – Resilience for services that support those who are in crisis to ensure their needs are provided in an appropriate care setting
- **Supporting our local people to access the care they need at the right time** – Implementing transformative improvement projects at pace to build greater system resilience and quality of care for our population

Year One Delivery Commitments

Personalised Care – Priorities for 2023/24

- Peer support development for the ARRS (Social Prescribing Link Workers and Health & Wellbeing Coaches)
- Build on existing Personal Health Budgets focusing on opportunities in Mental Health
- Digitalisation of Personalised Care and Support Planning focusing on Anticipatory care
- Continue the launch of the GetuBetter App to support those waiting for surgery or community physiotherapy and rehabilitation.
- Expanding Wellbeing circles to support Families with Children and Young People
- Implementing Proactive care and delivering Heart Failure @ home remote monitoring
- Working with our communities to recruit those with lived experience to support a co-produced offer supporting and developing peer leaders for the system (NHSE programme).
- 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
- 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.
- Support from Frimley Academy to provide opportunities for training and development of our workforce to hold community conversations and co-produce plans for improvement.
- 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.

Workforce – Ambitions for 2023/24

Ambition one – Creating a joint workforce model for health and care

- Create a joint health and social care career model and enabling structure to support greater agility in the system.
- Enabling the workforce to be in the right place at the right time and to support them to live well

Ambition two – Widening access to employment and keeping the people we have

- Identifying what works well to retain our people and support them to be their best
- Engage with our communities through an anchor institution approach to widen pathways into satisfying, valuable work.

Ambition three – Strengthening partnership working and new models of care

- Develop new and digitised workforce models to increase collaboration, productivity and align these to new models of care

Year One Delivery Commitments

Finance – Improving efficiency

Aligned strategy focused on **cost containment** and **reduction**

Managing / mitigating growth to ensure flow of income growth for deficit reduction.

Financial sustainability to provide **defined services** and **capacity** to meet patient need.

Utilising a system-first approach to transforming services for the benefit of our population regardless of organisational boundaries.

We will focus on providing defined services and capacity to meet patient needs. Partners will **not** engage in activities that aim primarily to **transfer costs**.

Trust, transparency and data sharing to do things efficiently and effectively.

Estates - Strategy

Achieve a safe, clean, secure, complaint fit for purpose estate and a progressive exist from poor quality and poorly utilised estates.

Enable the delivery of ICS clinical strategies and new models of care.

Enhance patient experience by creating welcoming and comfortable environments for patients, families

Meet regulatory requirements for environmental sustainability, ensuring focus on the drive toward NHS net zero carbon goals

Design facilities to support the delivery of care in cost effective and timely manner across ICS organisations.

Standardise technology so that multi-providers can effectively work within any building/facility for example to support care closer to home principles including access to results, near patient testing, and diagnostics

Unlock efficiencies through the improved utilisation of all the existing estate across all the organisations in the ICS and implement the recommendations following the reports by Sir Robert Naylor and Lord Carter in relation to the NHS Estate.

Reduce the burden of backlog maintenance and critical infrastructure risks