System Operating Plan
2019-20

FINAL 11th April 2019
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Executive Overview

This System Operating Plan describes the collective priorities and actions for the providers, commissioners and local authorities that make up the Frimley Health and Care Integrated Care System (ICS). The plan outlines how we will continue to deliver the overall vision of improved integration driving quality health and care improvements across our system.

As our ICS continues to develop, 2019-20 will be a significant year as we build upon on the successful changes implemented in 2018-19 whilst forming the foundations for future years and our longer term strategy. By working in partnership with our population and local partner organisations we will develop an integrated health and care system fit for the future.

In general, our population is relatively healthy and performs well against national averages but there are inequalities and challenges within the system. As this plan will form the foundations to support the refreshed 5 year strategic plan, the ICS Board has identified specific areas where collective system leadership, ambition and support will deliver accelerated improvements to deliver our longer term plan:

• Promote a focus on prevention across all of our transformation initiatives and cross cutting programmes and build a cross programme view of the impact of these initiatives on the future incidence of serious conditions and disease to inform longer term planning

• Continue to support and empower people to manage their own health and well-being with an increased focus on pro-active early intervention and greater access to self-management tools and resources

• Enabling everyone within our system to fulfil their potential by reducing inequalities and improving their mental well-being. Within our current transformation and cross cutting programmes, identify areas where outcome improvement should be targeted to particular cohorts of our population in addition to tracking outcomes for the whole population. We will deliver significant improvements within year for these targeted populations demonstrating a reduction in inequalities across the population as a whole. By the end of the year, we will agree a systematic approach for identifying and tackling inequalities and reducing unwarranted variation in care that will support delivery of our longer term plan

• Create sustainable “place based” delivery models building on established health and local authority footprints, integrated community care teams, community assets and emerging primary care networks. We will establish the infrastructure needed to support the long term planning aspiration of a fully integrated community based health and well-being service with a focus on prevention, proactive care, mental well-being and reducing inequalities. By the end of the year we will agree those functions and activities that will be delivered across the system and those where accountability will sit within more local community footprints (places)
Executive Overview

• As a system we have real challenges to address around children’s services (for both health and local authorities). We are committed to ensuring that all elements of a child’s health needs (both physical and mental health and well being) are considered. During 2019-20 we will embed a programme of improvement including the following key priority areas: Neurodiversity support, crisis and urgent care, and the promotion of well being and personal responsibility.

• We recognise that in order to deliver successfully across 2019-20 and into the future we will need to have a skilled and committed workforce that understands the challenges for people and works as increasingly integrated teams to deliver change and improvements. We will identify new roles and different ways of working that create capacity to allow our staff to have the time they need to deliver care and drive improvements. Through our Academy we will promote and support a learning and empowered culture, supporting people through innovative programmes and collaborative leadership styles.

Delivering this Plan is our opportunity to continue and to accelerate our plans to transform and improve the health, care and wellbeing of our population and to further build a system that is sustainable and that will continue to improve. By the end of this year we will have:

• Delivered on the priorities set out in this plan for the forthcoming year
• Developed an ambitious local vision and plan for the next 5 years co-designed with our population and supported by system partners across health and care. The plan will reflect national priorities for health and care but identifying the specific areas of focus for our populations
• Prioritised and concentrated our resources in our change programmes of work that will have the most impact for our population
• Made changes to the way our system makes decisions and reduced the barriers to successful delivery of improvements for our population
**Our Vision**

Our vision is to help people to be healthier and in their homes for longer. Across the Frimley Health and Care system we aim to work in partnership with our population and local partner stakeholder organisations to provide an integrated health and care system fit for the future. This means people receiving and having access to seamless holistic services that meet their physical and mental health needs at the earliest possible opportunity. Through a focus on the individual, as opposed to structure, we place an increased priority on prevention and pro-active care rather than reactive treatment. We expect to increasingly deliver the majority of an individual’s care needs in their local community and to reduce the need for hospital based care.

**This Plan** describes in detail what we will deliver in 2019-20 so that we continue to make rapid progress towards our vision for a high performing and sustainable health and care system. It builds on the successful changes implemented in 2018-19 and reflects national priorities for 2019-20, whilst laying the foundations needed for the next 5 years within the context of the NHS Long Term Plan. It includes:

- The detail of our system priorities and deliverables in our System Transformation Delivery Programme, which includes:
  - Seven established initiatives for which this will be year 2 of delivery
  - Five cross cutting programmes that ensure the national service priorities are delivered
  - Four established system enablers for the programme
- The System Financial Plan that delivers collective sustainability and meets our 2019-20 System Control Total. It includes our key system efficiencies and describes our arrangements for financial risk management. This section also describes our activity and capacity planning assumptions and system alignment
- Our approach to Workforce planning recognising the opportunities and challenges we face in shaping our workforce for the future
- How we will communicate and engage people with our collective ambition, the opportunity we have and the plans that will deliver it
- Work with partners across system boundaries when that will achieve the appropriate scale and opportunity, for example across workforce, cancer, specialist services, population health management and digital development
System Progress: Our strategic approach

Our Aims
All of the partners in the ICS are committed to putting residents first. In practice this translates to people receiving/having access to seamless holistic care that meets their need at the earliest possible opportunity. Through focussing on the individual, as opposed to the structure, we want to deliver an increased focus on prevention and pro-active care rather than reactive treatment. The partners are taking collective responsibility for simplifying the system and making it easier for people to understand and navigate it. Over time we want to see people leading healthier lives for longer across our population and local neighbourhoods.

To achieve this we will:

• Be a system with a collective focus on the whole population we support throughout their lives, not a system based on sectors, organisations services or parts of the population
• Work in increasingly integrated ways across disciplines and across organisations for the greater benefit of our residents
• Move our resources over time to those places of most need of investment to improve care and well-being. This will include a shift in investment over time to our out of hospital provision, a greater proportion of each annual allocation moving towards general practice, community and mental health provision and our prevention and self care agenda
• Achieve greater equity across health and care in our geography, so that those with the greatest need are a focus of priority investment and interventions, rather than all receiving the same irrespective of need
• Use our population health management tools and intelligence to target improvements more and more accurately to those points of greatest need and delivering the greatest value
• Address the wider determinants of health for those residents most vulnerable to environmental factors
• Maintain the stability of our component organisations and not destabilise parts of the system in order to achieve gains elsewhere
• Deploy digital advances and automated tools to support individuals and professionals to make better choices with more information
• Invest in developing the right workforce with the right skills, knowledge and understanding to transform our services and pathways

We will not work to achieve individual benefit for any part of the system that does not contribute to delivering better value to our residents over time. We will not focus on short term goals at the expense of a better set of health and well-being outcomes for our population over time.
System Progress: Where we are now

We have made considerable progress since the inception of the Frimley Health and Care STP/ICS in April 2016, and are now considered nationally as a leading Integrated Care System. The strength of the system comes from partners across health and local government working together with our local communities to improve the health and wellbeing of individuals in our population. We are using our collective resources more flexibly as part of a commitment towards achieving the best value for every ‘Frimley’ pound.

Our local residents are starting to see benefits already from the strengths of a system-based approach. Health and care workers are working more closely together providing people with a better experience from more joined up care. More of this care is provided in or near people’s homes, the number of people going to our A&E departments is not increasing and fewer people are being admitted to hospital overnight when they have an urgent health need. Support for people with mental health has been strengthened within our hospitals and fewer people with mental health problems are having to travel out of area for treatment.

Our GPs are developing more flexible ways for their patients to engage with them and all areas of our system now offer extended access on weekdays until 8pm and at the weekend in local GP practices for both routine and urgent needs. Both our GP practices and our local government partners are encouraging greater community involvement and support for residents, and encouraging more people to take responsibility for their own or their family’s health when formal support services are not the most beneficial response.

We continue to roll out plans which are in development. We have been running a series of public conversations to make sure that we understand the needs and preferences of our residents and that our plans will deliver what they need. Our system has benefited from additional funding for both transformation and capital developments. These plans have been developed across all partners and with our communities and delivery partners.

We are creating and using new roles across the delivery of health and care and we are seeing an increase in staff satisfaction, with retention and recruitment supported by new ways of increasing capacity. We have launched a new Leadership and Improvement Academy and are running flagship courses such as 2020 which are supporting more people to work collaboratively to drive improvements across the system.

All our work is supported by strengthened system governance and a move towards having a lighter touch regulatory assurance process agreed with our regulators, as we improve local system challenge and risk-based planning for the future.

Our population, communities and individuals will:

- Be supported to remain as healthy, active, independent and happy as possible
- Receive joined up care and support across our health and care system
- Know who to contact if they need help, being offered care and support in their home that is well organised, only having to tell their story once
- Work in partnership with their care and support team to plan and manage their own care leading to improved health, confidence and wellbeing
- Find it easy to navigate the urgent and emergency care system and most of their care will be easily accessed close to where they live
- Have confidence that the treatment they are offered is evidence based and results in high quality outcomes wherever they live - reduced variation through delivery of evidence based care and support
- Increase their skills and confidence to take responsibility for their own health and care in their communities
- Benefit from a greater use of technology that gives them easier access to information and services
- Be assured that care is provided in an efficient and integrated way
System Progress: Benefits already seen

We have achieved the following benefits for our residents and staff:

- Health and care workers are working more closely together
- People are reporting improved patient experience across the system with more joined up care being provided in peoples homes
- Patients have improved access to primary care teams from 8-8, Mon–Fri, and enhanced urgent care access 7 days a week
- There are more flexible ways of engaging with your GP
- There is greater community involvement and support in health and wellbeing
- Focused programmes in place aimed at helping people find community-based support for alcohol-related harm and physical inactivity
- Fewer people with mental health problems are having to travel out of the area for treatment
- CORE 24 liaison is being delivered by mental health liaison professionals to improve experience and outcomes for people with mental health needs in both Frimley Park and Wexham Park hospitals
- Perinatal services are now available across the entire footprint to ensure support for women experiencing mental health difficulties in the pre and post-natal period
- Employment support services are available across the footprint for people experiencing serious mental health problems
- Improving Access to Psychological Therapies (IAPT) services in place for people with long-term conditions – allowing us to connect mind and body
- Improved quality of care and support provided in care homes and people less likely to attend A&E, be admitted to hospital or have prolonged lengths of stay in hospital
- Improved pathways of care in areas like respiratory care, circulatory disease and musculoskeletal options, reducing variation of care in different parts of the system
- An increase in staff satisfaction, with retention and recruitment supported by the new roles and opportunities being developed
- Our shared care record allows our community workers to access information immediately, reducing the number of times people have to tell their story and improving care decisions
- There has been greater investment in the local system, capital and transformation funds, with the new Emergency and Assessment Centre at Wexham Park Hospital now fully operational
Our Frimley Health and Care 2018-19 Operating Plan priorities were based on the evidence of health needs from the five local Joint Strategic Needs Assessments (JSNAs). Whilst the overall shape of these health needs changes quite slowly, we need to take account of some important future trends:

- The population is growing
- The population is becoming more diverse
- More people are living alone
- After recent growth, the number of births each year is expected to level off
- The population is ageing
- Health inequalities persist

A trend or need at a system level can be very different at neighbourhood (e.g. Ward) level. For example, life expectancy in the Frimley Integrated Care System (ICS) has increased and is significantly higher than the England figure for both men and women, whilst in several Wards it remains materially lower than national benchmark. There is a 12 year difference in life expectancy across the Wards of the Frimley ICS.

In recognition of this, we are currently transforming the way in which we look at health needs through our Population Health Management programme. This is being done in alignment with both Berkshire West and Surrey Heartlands Integrated Care Systems across three themes:

- **Infrastructure**: We are enhancing the data within our Connected Care information system to include wider determinants of health and wellbeing such as socio-economic data. A large scale communication programme is being developed to discuss with residents how use of this data helps us improve health, wellbeing and services. We will continue to protect residents’ personal data through strong governance of information and it will not be used outside the health and care system

- **Intelligence**: The information available is becoming much richer than that previously available. We are working with clinicians, and particularly with GPs, to draw out the insights at a neighbourhood level, and with experts in Public Health and elsewhere to explore how we can better identify emerging needs. These activities will reshape our 2019-20 Operating Plan and underpin our 5 year strategic plan

- **Intervention**: We will use the insights about local needs to make joint decisions across Health and Local Authorities about the priorities and action needed in each locality as well as system-wide. The Health and Wellbeing Boards will have a primary role in this to create comprehensive local health and wellbeing plans
The Wider Determinants of Health

The wider determinants of health (WDH) are important if we are to improve the length and quality of life experience by local people. Wider determinants of health have the biggest impact on health outcomes, with factors such as education, employment and income contributing to 40% of health outcomes (length and quality of life). This is closely followed by health behaviours (30%), such as smoking and alcohol; with access and quality of clinical care only contributing to 20% of outcomes; and the built environment contributing 10% to health outcome.

The Frimley Health and Care ICS, along with our voluntary sector partners, will play a key role supporting the preventative agenda across Frimley. Closer collaboration and partnership working with Health, local government and the Voluntary, Community and Faith Sector (VCFS) will facilitate a more holistic, joined up approach to managing the health and wellbeing of all residents at place.

In order to provide focus on the wider determinants of health for all stakeholders within the coming year, it is envisaged that the ICS will concentrate on the below priority areas: housing; planning; an asset based approach to support community health, wellbeing and resilience and the NHS responsibility around the WDH.

- **Housing** - adoption of recommendations contained within the Kings Fund Housing and Health Paper March 2018
- **Planning** - influence the wider determinants of health through the built and natural environments
- **Asset based approach** - to support community health, wellbeing and resilience
- **WDH responsibility of the NHS** - for example, the role of the NHS to improve air quality by using technology to reduce health related journeys

Action plans for each priority area will be developed in the coming months as part of our response to the NHS Long Term Plan.
1. Prevention and Self-care: Ensure people have the skills, confidence and support to take responsibility for their own health and wellbeing.

2. Integrated care decision-making: Develop integrated care decision-making models in each locality to improve health and care outcomes for our populations and reduce demand on health and care resources.

3. GP Transformation: Lay foundations for a new model of general practice provided at scale, including development of GP networks to improve resilience and capacity.

4. Support Workforce: Design a support workforce that is fit for purpose across the system.

5. Care and Support: Transform the social care support market including a comprehensive capacity and demand analysis and market management.

6. Reducing clinical variation: Reduce clinical variation to improve outcomes and maximise value for individuals across the population.

7. Shared Care record: Implement a shared care record that is accessible to professionals across the ICS footprint.

National ‘must do’s’:
- Primary Care
- Urgent and Emergency Care
- Referral to treatment times
- Cancer
- Improving quality
- Financial sustainability
- Development of high quality ICS

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection

Priority 2: Action to improve long term condition outcomes including greater self management and proactive management across all providers for people with single long term conditions

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence

Cross cutting Programmes
- Urgent and Emergency Care
- Mental Health and Learning Disabilities
- Maternity
- Children and Young People
- Cancer
- Medicines Optimisation

Enablers
- Workforce
- Estates
- Digital & Technology
- Communication & Engagement
Our Local and Organisational Priorities for 2019-20

Aim
This plan gives a system overview of the collective priorities and parameters for the organisations that form our ICS. Whilst as a system we are working closely together to maximise the impact of our programmes of work, we are also committed to addressing local and organisational needs. Within the context of the system plan this section highlights some of the areas of particular emphasis for stakeholder organisations and how this is shaping our planning and delivery approach in 2019-20. Further organisational detail is provided in Appendices 4 and 5.

Highlights

• Most of the delivery of the system plan occurs within local geographies with local populations and through front line staff. Consequently, many of the areas highlighted reflect place and/or organisational details that will deliver the system plan. These details are often critical for local population and staff engagement.

Quality, safety and a positive experience for people are important drivers. Delivering these outcomes are important to the ICS and a system wide structure had been put in place to provide leadership and support as detailed in the System Governance section of this plan.

• Enablers to delivery change are focus areas for stakeholder organisations: Workforce, Estates and Digital and Technology transformation are key areas of operational focus. The ICS is reviewing as part of its preparation for 2019-20 the interface between system enablers, the capacity required to manage change in these areas, the delivery that takes place within organisations and how learning is shared.

• Securing the right services for people is important for all organisations. Going forward, the system will explore the full range of options for commissioning the right services for our population based on analysis of need.

• The redesign of our Continuing Healthcare Services has been highlighted by each of the three CCG areas. This is due to the complex geography of the ICS and its work across multiple local authority footprints and we will share the learning from this across the ICS whilst recognising the appropriateness of these planning and delivery footprints to each local area.

• The is a strong programme of activity around services for children and young people. The ICS has added to this year’s plan a delivery structure and cross cutting programme for children and young people (see Section 7 Cross Cutting Programmes).

Challenges and Opportunities

• The local and organisational priorities highlight some current service gaps, and some risks around non-recurrent funding sources supporting care delivery. The ICS partners will develop more collective approaches to funding and investment decisions. This will require open and transparent conversation with our communities on how we provide the best possible care within a limited financial resources.

• There is an opportunity as part of the development of the ICS long term plan to bring together our current thinking as a system to form a coherent single strategy for health and wellbeing for our population.
The Frimley Health and Care system has established a transformation and delivery programme through which this system plan will be operationalised. The programmes of work are designed to transform the way care is delivered to the benefit of the system population and enable delivery of the system and national priorities. Each initiative consists of a portfolio of work to support delivery of our transformation agenda. There are also a number of transformational enablers that underpin the work including workforce, estates, digital, communications and engagement and technology that are described more fully in Section 7 in this plan.

**Context**

Since the publication in November 2016 of the Frimley Health and Care Sustainability and Transformation Plan, we have increased the number of our transformation and delivery initiatives in order to deliver our system and national priorities. The totality of these programmes of work span our transformation agenda and provide a coherent view as to how we will deliver transformed health and care services to the benefit of our system population. The programmes have been influenced by a number of different sources including national and system priorities, NHS RightCare methodology and packs, current system performance and challenges, and with reference to local public health profiles and health and wellbeing strategies.

Plans have been developed with input from all partners across the Frimley footprint with a strong focus on being clinically led where appropriate. As a system we have in place a robust investment planning process to support the initiation and delivery of our transformation projects. For 2019-20, each of the initiatives within the work programme has a refreshed set of deliverables, milestones, outcomes and benefits, risks and issues. Steering Groups are in place for each initiative and they are delivered through sub-groups that are clinically led (where appropriate) with members representative of all organisations across the system as relevant. The system has an established PMO (Programme Management Office) to develop, support and track the benefits and outcome measures for each of the key initiatives. Oversight for this office sits with the Programme Director who is accountable to the Programme Delivery Board and ICS Board.

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<td>2. Integrated Care Decision Making</td>
<td>• Mental Health and Learning Disabilities</td>
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<td>3. GP Transformation</td>
<td>• Maternity</td>
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<td>4. Support Workforce</td>
<td>• Children and Young People</td>
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<tr>
<td>5. Care and Support Market</td>
<td>• Cancer</td>
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<td>6. Reducing Clinical Variation</td>
<td>• Medicines Optimisation</td>
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<td>7. Shared Care Record</td>
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**Our 2019-20 Transformation Delivery Programme**
Emerging Delivery Structure

ICS Board

Programme Delivery Board

Local Governance & Delivery

Cross Cutting Programmes
- Clinical Reference Group
- Quality & Performance Committee
- Frimley ICS UEC Delivery Board
- Mental Health & LD SG
- Local Maternity SG
- Children & Young People SG
- Local Cancer System SG

NED / LAY Assurance Group
- H&W Alliance Board
- Finance Reference Group
- Workforce / Leadership

Enablers
- Comms
- Estates
- Digital & Technology
- Population Health

KEY
- System
- Assurance
- Change
- Local

OSC Chairs / Healthwatch
- External Stakeholders

ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR
1. Prevention and Self-care

**Aim**
The sustainability of our health and social care system depends on people living healthier for longer. In order to achieve illness prevention at the required scale we will need to transform our approach. In particular, we need to move beyond delivering prevention programmes to our population and start creating prevention programmes with them.

**Description**

The NHS Long Term Plan includes a clear focus on “Prevention, personal responsibility and health inequalities”. The explicit inclusion of inequality comes at the same time as an increasing national focus on the wider determinants of health, such as poverty, education, employment, social isolation and the environment (Kings Fund, 2018). The plan sets out the role the NHS must play in delivering the wider determinants of health, including improving air quality, in partnership with local government and communities at place.

Addressing these factors requires that we get beyond ‘traditional’ preventative programmes that focus solely on individual behaviour. Rather, we need to attend to the social context in which these behaviours occur and the extent to which local communities can be a source of health improvement. Within this, our core ambition should not be to deliver prevention programmes to our population but to create prevention programmes with them. Only this approach will give us the sustainability and scale of health improvement that we need going forward.

In 2018-19, our ICS Prevention and Self Care work stream established a ‘community asset based’ approach that seeks to fully harness the knowledge, experience and energy of our population. We worked to propagate a coherent, evidence-based approach to community development across the ICS area, with the development of ‘social prescribing’ programmes across all five local authority areas as well as the extension of the Making Every Contact Count (MECC) Programme to social care and community settings.

The ‘social’ focus of the Prevention and Self Care work stream in 2018-19 also included a new approach to working with online communities and social media. For example, by harnessing the combined social media reach of a wide range of ICS partners, the #MovingCan physical activity campaign reached over a quarter of a million people and produced significant increases in the uptake of community based physical activity programmes.

In 2019-20, the focus on wider determinants of health will continue, with particular attention to those areas facing the largest challenges in terms of poverty, employment and social isolation. This in turn will require the incorporation of data on social factors into key health and care datasets as well as targeted health improvement work designed and delivered in collaboration with local community leaders.
1. Prevention and Self-care

**Deliverables**

**Social Prescribing**
**Why?** Social prescribing services help residents find and access community based health improvement opportunities.
**What?** Maintenance of the five social prescribing programmes that now exist across the Frimley system with evaluation of the impact on health status (measured via R-Outcomes). Piloting of an automated digital ‘social prescribing’ system within four community locations (in Bracknell Forest – funded by NHS Digital award).
**Delivered** at neighbourhood and place level.

**Making Every Contact Count (MECC)**
**Why?** Evidence suggests that brief advice from health and care professionals and implementing nudge theory techniques significantly increases the likelihood of health behaviour change.
**What?** Training will be rolled out for staff across the Frimley system and extended to all local authority social care staff (building on the two already engaged in 2018-19). A total of 450 staff will be trained in 2019-20 which represents an increase of 50% on 2018-19.
**Delivered** at neighbourhood and place level.

**Hospital Based Alcohol Services**
**Why?** There are around 13,000 admissions each year across the ICS footprint. Evidence shows brief advice in hospital can reduce admissions.
**What?** Behavioural advice and support is offered when patients are in hospital for alcohol related reasons. Monitoring will take place in relation to NHS Digital quarterly reports of alcohol related admissions with the ambition of achieving a 5% decrease from 2018/19 levels by March 2020.
**Delivered** at place and system level.

**Physical Activity Initiatives**
**Why?** Nearly a quarter of adults in the ICS footprint are active for less than 30 minutes a week, increasing their risk of long term health problems.
**What?** The range of accessible opportunities for activity will be further developed and promoted with a particular focus on community programmes that have proven health benefits (e.g. walking groups). Work with the ICS Communications teams will ensure the success of the 2018 #MovingCan campaign is repeated with a #MovingIs initiative. This will focus on highlighting ways of becoming active beyond traditional sports (e.g. gardening, walking etc.).
**Delivered** at neighbourhood and place level.

**Links to Other Work streams**
**Why?** To achieve the scale of demand reduction required, prevention work needs to run as a ‘gold thread’ throughout all ICS programmes.
**What?** Prevention and Self Care leads will be established in other work streams to ensure that prevention is being attended to and that referral pathways to preventative services are in place. This work will begin with the Reducing Variation Programme.
1. Prevention and Self-care

How will services look by the end March 2020?

By March 2020, people living within the Frimley Heath and Care ICS area will have numerous, easily accessible options for improving their level of positive social contact. This includes Social Prescribing Services that will help people find and join a community group that is right for them. As a result, people will experience a measurable positive impact on their health and well-being. In particular, people in our area will find a wealth of options for getting more physically active no matter what their level of fitness or mobility.

Those wishing to run set up and run their own community projects will receive support and resources to make their ideas a reality. This will apply to people living in all areas of the ICS patch regardless of the level of economic deprivation.

When people in our area access health or social care services they will find that the staff they encounter are able and willing to offer healthy lifestyle advice. In particular, anyone who has to access healthcare due to alcohol misuse will find support is available from trained staff who can help them reduce their alcohol intake and refer them to specialist alcohol treatment programmes if necessary.

Outcomes and Benefits

- An improvement in Health Status scores from pre to post Social Prescribing Service use of at least 4 points (data source - R-Outcomes reports from local services)
- An increase of 50% (from 2018-19) of staff trained in 2019-20 which will enable them to work in a more person centric approach to addressing inequalities in health and therefore make them less reliant on health and care services
- Increase in 2% across all areas in the proportion of people meeting at least minimum recommended levels of physical activity (data source - Sport England Survey)
- A reduction in alcohol related admissions of at least 5% on 2018-19 levels across all ICS areas (data source - NHS Digital quarterly publication)

Key Risks and Mitigation

- Lack of public engagement in initiatives. This risk will be mitigated through a continual review of communication across ICS through a range of methods to ensure engagement
- Lack of staff engagement impacting prevention opportunities. This risk will be mitigated by holding workshops and training throughout the footprint, including catch up sessions with thorough documentation
## 1. Prevention and Self Care

### Outcomes and Benefits

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<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
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<tr>
<td>Neighbourhood</td>
<td>~50k</td>
<td>• An improvement in Health Status scores from pre to post Social Prescribing Service use of at least 4 points (data source - R-Outcomes reports from local services)</td>
<td></td>
</tr>
<tr>
<td>Place</td>
<td>~250-550k</td>
<td>• Each local authority / CCG area will see an improvement in Health Status among residents using the local social prescribing service</td>
<td>• An increase of 50% (from 2018-19) of staff trained in 2019-20 which will enable them to work in a more person centric approach to addressing inequalities in health</td>
</tr>
<tr>
<td>System</td>
<td>1m+</td>
<td></td>
<td>• A reduction in alcohol related admissions of at least 5% on 2018-19 levels across all ICS areas</td>
</tr>
</tbody>
</table>
1. Prevention and Self Care

**Milestones**

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2018-19 Annual Report finalised</td>
<td>• Q1 report (showing data on SP, MECC and Alcohol Services by end July 2019)</td>
<td>• Q2 report (showing data on SP, MECC and Alcohol Services by end October 2019)</td>
<td>• Q3 report (showing data on SP, MECC and Alcohol Services by end January 2020)</td>
</tr>
<tr>
<td>• Funding arrangements for Social Prescribing (SP) services confirmed (by end April 2019)</td>
<td>• Prevention Programme’s interfaces with other ICS programmes defined and delivery plans signed off by Programme Delivery Board (by end July 2019)</td>
<td>• All local authority Social Care departments trained in MECC (by end October 2019)</td>
<td>• First staff in voluntary sector trained in MECC (by end January 2020)</td>
</tr>
<tr>
<td>• Pilot of automated digital social prescribing pilot in Bracknell Forest launched (by end May 2019)</td>
<td>• Prevention and Self Care Showcase Event held and feedback disseminated (by end August 2019)</td>
<td>• Evaluation of pilot of automated digital social prescribing in Bracknell Forest completed (by end November 2019)</td>
<td>• Business case for roll out of automated digital social prescribing programme across ICS submitted (by end March 2020)</td>
</tr>
<tr>
<td>• 110 Staff trained in MECC (by end June 2019)</td>
<td>• Social Prescribing recurrent funding confirmed and staffing arrangements in place (by end August 2019)</td>
<td>• 330 Staff trained in MECC for 2019-20 (by end December 2019)</td>
<td>• Design of Spring 2020 Physical Activity Campaign completed (by end February 2020)</td>
</tr>
<tr>
<td>• Spring 2019 #MovingIs Physical Activity Campaign completed across whole ICS (by end June 2019)</td>
<td>• #MovingIs campaign completed with target of 750,000 social media reach (by end August 2019)</td>
<td>• Plans for having voluntary sector trained in MECC agreed (end January 2020)</td>
<td>• Total of 450 staff trained to give healthy lifestyle advice (MECC) including those in health, social care and voluntary sector. This will represent a 50% increase on 2018-19 (data source – ICS MECC team)</td>
</tr>
<tr>
<td>• Asset based toolkit complete and included in ICS website</td>
<td>• Pilot of automated digital social prescribing in Bracknell Forest delivered to first 100 people (by end September 2019)</td>
<td>• 330 Staff trained in MECC for 2019-20 (by end December 2019)</td>
<td>• Plans for having voluntary sector trained in MECC agreed (end January 2020)</td>
</tr>
<tr>
<td></td>
<td>• 220 total staff trained in MECC for 2019-20 (by end September 2019)</td>
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</tbody>
</table>

1. Prevention and Self Care...
2. Integrated Care Decision Making

**Aim**
The aim of the Integrated Care Decision Making (ICDM) initiative is to drive the delivery of a model of integrated care provision within each of our localities across the ICS which achieves improved health outcomes for our populations, reduces the burden of demand on health and care resources over time, and in turn supports our plans for a sustainable health and care system. We will be focused on developing a common approach to managing individuals living with frailty and multi-morbidities. The ICDM model is underpinned by strong partnerships with social care, general practice, secondary care and community services, and the voluntary sector. Its development at a local level has been informed by, and will be implemented through, ongoing engagement.

**Description**
The model for integrated care is aimed at the improved management of those living with frailty or multiple complex physical and mental health long term conditions. The integrated approach will support and empower people to maintain independence and control, to manage their multiple health and care conditions locally, and will provide wrap-around care for people in or close to their own homes wherever possible.

The Integrated Care Decision Making (ICDM) programme is a critical element of delivering the Frimley Health and Care ICS System Operating Plan. The delivery of integrated care is nationally recognised as being the most effective approach to achieving improved health outcomes for those with long term conditions or frailty. The ICDM programme focuses on the development of an integrated care model within communities focusing on those with moderate to severe care needs. Our model for integrated care will ensure that by having clear signposting and an intuitive system, it will be easier for people to access timely, seamless and holistic care in the most appropriate place. Key elements of the ICDM model include multi-disciplinary teams (MDTs) across health and social care working together rather than within separate functions, a focus on anticipatory care of segmented populations at risk and the availability of integrated locality access points as a single contact point for professionals.

During 2019-20 the ICDM programme will transition to consolidate the development of integrated care at place-based level. This should align with the development of Primary Care Networks, urgent care, prevention and wellbeing, and mental health.

The benefits of the service are that it will deliver a more responsive proactive care model, shifting the balance of spending and health outcomes over time. Locality-based operating models will be implemented consistently across all areas, and will be strengthened and aligned over the next five years. These models represent a radical shift from traditional models of reactive care to a proactive anticipatory outcome-based approach.

A fully integrated care model will enable people to stay healthy and independent for longer, leading to improved long term outcomes and fewer crises. This will result in a reduction in unplanned admissions, prolonged hospital stays and long term care provision, thereby reducing avoidable demand on primary, community and secondary care services.
2. Integrated Care Decision Making

Description

The overall objectives are as follows:

• Delivery of an integrated service model across East Berkshire which builds on the successes achieved through the North East Hampshire and Farnham (NEHF) CCG Vanguard and Surrey Heath CCG, thus delivering an integrated approach across the whole of the Frimley Health and Care ICS
• A move from reactive care provision to one where care needs are identified in a proactive and anticipatory care planning becomes the norm, alongside rapid access to locally delivered multi-agency services which bring together health, social care and our community partners, and which provide a platform for the delivery of the Primary Care Network enhanced services contract requirements and support a sustainable model of general practice and community services
• Demand for all forms of unplanned and some scheduled care services reduces over time, and local health and care resources are used in a way that enables people to stay within their community wherever possible
• Locality and Network level service models which ensure joined-up primary and community care, particularly for those of highest risk and with multiple long term conditions and complex needs
• In conjunction with other System programmes; to develop our primary and community workforce, introducing roles which support integration across organisational boundaries and which support the expansion of best practice and innovative ways of working
• To use data sources such as the eFl, population health intelligence, Right Care, and other risk/predictive modelling tools to create a consistent approach to the identification of those who would most benefit from this integrated care model
• To improve staff satisfaction and create a person centred approach through the effective and timely sharing of information and care plans

How will services look by the end of March 2020?

The Integrated Care Decision Making programme supports the delivery of the following:

• A focus on prevention and through an anticipatory care model supporting people remaining independent for longer, reducing the likelihood of health crises and a subsequent need for ongoing long term care: Help, support and clear signposting will be available earlier, making it easier for people to access the appropriate care and support where needed. The care that people receive will be more joined-up and they will be involved in the future planning of their own care
• Early access to anticipatory integrated services for individuals identified as having moderate and severe frailty and multi-morbidity, as well as those people at risk of falls and those in the final 12 months of life; this will be underpinned through improved care planning and co-ordination ensuring that patients achieve improved health outcomes and do not get lost in the system. Through the identification of need through a more anticipatory approach, the impact of crises on both individuals and health and social care system will be reduced over time. Through the development of the scope of multidisciplinary teams at place to include mental health, wider community services and the third sector, more staff will be part of integrated teams, working together across organisational boundaries via a ‘can do’ philosophy to deliver care and support that is tailored to address the specific needs of individual patients. By adopting joint and trusted assessments and care planning the amount of time released will be maximised, enabling staff to deliver front line care and support. Overall, people’s experience as users of health and care services will be improved and more personalised
2. Integrated Care Decision Making

Deliverables

Network

• **Agreed Locality Access Points (LAPs):** To enable timely access to integrated interventions, triage and case management

• **Community Integrated Care Teams:** Multi-disciplinary teams (MDTs) working across organisational boundaries in our communities, co-located with Primary Care services where feasible and staffed with an appropriate skill mix to effectively manage people at high risk of hospital admission or re-admission

• **Regular MDT Cluster meetings:** MDT approach which results in a structured individual care plan that involves active interventions which promote opportunities for recovery to independence, and reduce demand on crisis and urgent care services

• **Embedded Anticipatory Care approach:** Proactive case finding/risk stratification of patients which identify patients who are at high risk, enabling pro-active interventions to avoid unnecessary hospital admissions and reducing the need for long term care

Place

• **Supporting delivery of the NHS Long Term Plan:** Place-based mapping of primary and community requirements undertaken in order to support delivery of the Plan

• **Alignment:** Ensure that integrated care aligns with the requirements of General Practice and Primary Care Networks, social care, urgent care, prevention and wellbeing, and mental health redesign, and the estates and technology transformation programmes

• **Improve independence:** Helping people maintain independence and manage their own health and care e.g. through expanded use of social prescribing, social, emotional and psychological support in partnership with the individual

System

• **Shift demand:** Reduced crises, impacting on pressures and targets associated with unplanned emergency activity, reduced bed days and admissions into long term care

• **Decrease secondary care activity and support the reduction in costs:** Sustained shifts of activity and demand will enable long term financial sustainability

• **Improving the health outcomes and independence of those most at risk in our populations:** Enabling people to remain independent in their own homes for longer
2. Integrated Care Decision Making

**Outcomes and Benefits**

- Improved management of people who are frail and have multiple long term conditions
- Improved experience and satisfaction of individuals receiving assessment and support
- More people maintaining independence
- Increase use of self-management options e.g. social prescribing
- Improved staff job satisfaction and recruitment and retention
- Reduction in the number of and spend associated with long term care placements in adult social care using a baseline of outturn 2018-19
- Agreed modelled cost benefits associated with reductions in non-elective/elective activity/length of stay
- Reduction in duplication of services
- Improved use of health and care resources

**Key Risks and Mitigation**

- Insufficient workforce capacity and resources within primary and community teams to support anticipatory care and to provide interventions for people identified as living with frailty. This risk will be mitigated through a locally led capacity ‘mapping and gapping’ exercise to identify areas of specific focus for redesigning or investment
- Insufficient workforce capacity and resources in Primary care to engage as a pivotal part of the multi-disciplinary teams (MDTs). This risk will be mitigated through co-ordination between the GP Transformation programme, the evidenced positive impact of MDTs on releasing time to care, and professional leadership across the programme linked to continuous communication and engagement at locality member practice meetings
- Inconsistent approach to identifying those individuals who most benefit from both the MDT and Anticipatory care approach. This risk will be mitigated through the application of recommended best practice from the Frailty Advisory Board and the close monitoring by the ICS analytics and the Commissioning Support Unit (CSU) on the utilisation of risk stratification tools and the eFI tool incorporated within Primary Care IT systems
- Consistent approach to the use of evidence-based interventions not being adopted across the ICS, and services become fragmented. This risk will be mitigated with local project leadership to oversee and to escalate to the Steering Group as needed
- Programme fails to deliver the assumed system benefits. This risk will be mitigated via continued engagement with clinical leaders through clinical leads, member practice meetings and interface with the GP Transformation programme
- The complexity of the organisational and demographic make-up of East Berkshire presents particular challenges to the pace of delivery of locally appropriate models of integrated care. It is paramount that the model reflects all the agreed elements and aligns with both the transformation of primary and community services and the opportunity to optimise integration with local authority resources, whilst positively impacting reducing health inequalities at place. These challenges are mitigated through robust local leadership and governance underlined by continued engagement with partners and stakeholders. Strong alignment with other key system workstreams including Primary Care transformation, Prevention and Wellbeing and Mental Health will also ensure the success of implementation and mitigate duplication.
## 2. Integrated Care Decision Making

### Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood</td>
<td>~30-50k</td>
<td>• Improved management of people who are frail and have multiple long term conditions&lt;br&gt;• Improved experience and satisfaction of individuals receiving assessment and support&lt;br&gt;• More people maintaining independence&lt;br&gt;• Increase use of self management options e.g. social prescribing</td>
<td>• Improved staff job satisfaction and recruitment and retention&lt;br&gt;• Reduction in the number of and spend associated with long term care placements in adult social care using a baseline of outturn 2018-19&lt;br&gt;• Agreed modelled cost benefits associated with reductions in non elective/elective activity/LOS&lt;br&gt;• Reduction in duplication of services&lt;br&gt;• Improved use of health and care resources</td>
</tr>
<tr>
<td>Place</td>
<td>~250-550k</td>
<td></td>
<td>• Financial benefit with reduced non elective/elective activity/LOS&lt;br&gt;• Improved recruitment and retention through new models of care&lt;br&gt;• Improved staff job satisfaction and recruitment and retention through increased joint working between partner agencies and co-location of staff&lt;br&gt;• More effective use of resources</td>
</tr>
<tr>
<td>System</td>
<td>1m+</td>
<td>• Increased use of Advanced Care Plans with an increase in patients dying in preferred place of death</td>
<td>• Improved confidence of healthcare professionals to deliver EoL care benefits&lt;br&gt;• Significant contribution to delivery of System Operating Plan and financial sustainability&lt;br&gt;• Achievement of priority areas of strategic improvement</td>
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## 2. Integrated Care Decision Making

### Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td>• MDT meetings established across East Berkshire with extended professional representation in support of complex, crisis and anticipatory care patients, replicating the existing provision in the rest of the ICS footprint</td>
<td>• Business case for resources for extending community capacity where needed back to PDB for approval</td>
<td>• Locality Access Points (LAPs) will be extended to operate across East Berkshire from 8am - 8pm Monday to Friday, replicating the existing provision in the rest of the ICS footprint</td>
<td>• eFI used as the primary tool for identification of frailty across all localities</td>
</tr>
<tr>
<td>• Local workforce and service capacity mapping and gapping completed against demand modelling and gaps translated into local workforce and investment plans</td>
<td>• Falls fracture liaison service in place across the system</td>
<td>• Community-based services across East Berkshire developed as integrated care teams in line with Locality Access Point accessibility 8am – 8pm, replicating the existing provision in the rest of the ICS footprint</td>
<td>• Additional recruitment identified for development of community-based services to be accessible as a minimum Monday to Friday 8am – 8pm</td>
</tr>
<tr>
<td>• Future investment proposals presented to ICDM steering group for consideration and recommendation to Programme Delivery Board (PDB)</td>
<td>• System wide End of Life Care strategy signed off at PDB</td>
<td>• Community-based services across East Berkshire developed as integrated care teams in line with Locality Access Point accessibility 8am – 8pm, replicating the existing provision in the rest of the ICS footprint</td>
<td></td>
</tr>
<tr>
<td>• Frailty Liaison services in place 70 hours per week</td>
<td>• ICS EoL strategy Implementation plan agreed</td>
<td>• Access from hospital to local community services delivered via an integrated access point</td>
<td></td>
</tr>
<tr>
<td>• List of core interventions post anticipatory care agreed for use across the ICS</td>
<td>• Access from hospital to local community services delivered via an integrated access point</td>
<td>• MDT meeting frequency increased to satisfy demand without creating waiting lists – phasing linked to workforce modelling and recruitment</td>
<td></td>
</tr>
<tr>
<td>• ICS End of Life (EoL) strategy completed and presented to steering group for approval</td>
<td>• MDT meeting frequency increased to satisfy demand without creating waiting lists – phasing linked to workforce modelling and recruitment</td>
<td>• Transition plan agreed for ICDM programme to form part of the local delivery model for Primary Care Networks</td>
<td></td>
</tr>
<tr>
<td>• Falls strategy and implementation plan produced and recommended for approval</td>
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</tbody>
</table>
3. General Practice Transformation

**Aim**
The aim of the General Practice Transformation Programme is improve resilience and stability at practice level and transform the care and services provided by general practice to its local population in line with system priorities. This will require a more affective approach to workforce and physical capacity planning in primary care and a clearly articulated offering from general practice that supports prevention, self-care and early detection, multiple and single long term conditions management and urgent care services.

**Description**
General practice is the bedrock of the NHS and has one of the highest public satisfaction ratings of any public service. Good quality general practice is considered an essential feature of all cost-effective healthcare systems. Strengthening and transforming general practice is crucial for it to continue to deliver high quality services and to enable it to have an impact on system demand and optimise use of finite NHS resources.

Of the many external influences on general practice the ageing population is having the greatest impact. The increase in life expectancy has been accompanied by an increase in the number of people living with chronic ill health and had led to a significant increase in the demand for general practice. Increasing choice and service integration, providing care closer to home and placing a stronger emphasis on patient involvement have also further increased the expectations of, and demands on, general practice. As the pressure on primary care is rising, the general practice workforce is ageing and within the Frimley ICS 49% of the general practice workforce is over 55. Increasingly practice staff are salaried, working part time and retiring earlier. Workforce shortages present the greatest risk to delivery of our system priorities both from a care delivery perspective and the leadership role required from general practice. Increased investment in the primary care workforce and new roles and ways of working are key priorities for 2019-20.

Primary care networks are the building blocks for general practice at scale. The approach is for networks to be ‘right size’ for their populations, bringing in the key themes of population health management, care focused on the needs of their local population with the potential for shared assets and workforce. We have 10 networks ranging in size from 28,000 to 156,000. During 2019-20, we will build on the formation of networks, increasing the range of projects that are delivered at scale and through partnership working on place based footprints. Benefits will include:

**For patients and carers:** Joined up services, access to a wider range of professionals and diagnostics, different ways of getting advice and treatment, shorter waiting times, greater involvement in care decisions and an increased focus on prevention.

**For practices:** Greater resilience by sharing staff, buildings and other resources, a more sustainable work/life balance, more satisfying work with a greater ability to focus on the tasks they do best, greater influence on decisions made elsewhere in the system and the ability to provide better treatments.

**Wider health and care partners should experience:** Cooperation across organisational boundaries, primary care providers as core partners in system decision making, alternatives to default acute services and more resilience primary care.
3. General Practice Transformation

**Description**
The aim for 2019-20 is to establish key building blocks that will be required to deliver the current system priorities and future strategy for primary care. The General Practice (GP) Transformation Programme will have three roles during 2019-20:

1. Strategic role: Produce a Primary Care Strategy which is co-designed with general practice, its population and partners and aligned with the system’s vision for the future
2. Oversight role: Identify and support the delivery of key primary care building blocks that sit outside the GP Transformation delivery programme ensuring the totality of the change programme for general practice is visible, prioritised and appropriately resourced
3. Delivery role: Own the delivery of the activities and outcomes contained within the GP Transformation Work Programme as described below

The collective changes planned for 2019-20 will impact on the organisational, career and service model of general practice and the capacity required from general practice to develop new competencies and implement these changes should not be underestimated. The changes planned for 2019-20 form much of the foundation required to deliver the system priorities.

<table>
<thead>
<tr>
<th>Area</th>
<th>Foundations for Change (building blocks)</th>
<th>Delivery Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>Scale opportunities including place based delivery (Primary Care Networks)</td>
<td>GP Transformation Programme</td>
</tr>
<tr>
<td></td>
<td>Physical capacity planning (Primary Care Estates Strategy)</td>
<td>Estates Programme</td>
</tr>
<tr>
<td></td>
<td>Improved demand and capacity transparency</td>
<td>GP Transformation Programme</td>
</tr>
<tr>
<td></td>
<td>Care data analytics for greater population segmentation and risk stratification</td>
<td>Population Health Management</td>
</tr>
<tr>
<td>Career</td>
<td>Workforce planning (Primary Care workforce strategy)</td>
<td>GP Transformation Programme</td>
</tr>
<tr>
<td>Service</td>
<td>Integrated community provision model (including care homes)</td>
<td>Integrated Care Decision Making, Care &amp; Support Market</td>
</tr>
<tr>
<td></td>
<td>Parity for mental and physical health: new service model for primary care mental health /wellbeing</td>
<td>Mental Health &amp; GP Transformation Programmes</td>
</tr>
<tr>
<td></td>
<td>Connecting Care Providers – Shared Care Record</td>
<td>Connected Care</td>
</tr>
<tr>
<td></td>
<td>Self management – Expansion of on-line services</td>
<td>GP Transformation Programme</td>
</tr>
<tr>
<td></td>
<td>Focus on prevention and early detection</td>
<td>Prevention and Self-care, Reducing Clinical Variation, Cancer, Primary Care Networks</td>
</tr>
<tr>
<td></td>
<td>Developing a clearly articulated urgent care offering from primary care</td>
<td>GP Transformation Programme</td>
</tr>
</tbody>
</table>
3. General Practice Transformation

**General Practice Programme Delivery Areas (Delivery Role)**

The overall goals of the programme for 2019-20 are as follows:

- Develop a shared vision for general practice
- For general practice to have an equal *voice* in collective system level decision making
- To **optimise and maximise** the benefits of existing programmes of works in the strengthening and development of primary care
- Recurrent investment in general practice is increased to deliver system priorities and improved patient outcomes

The General Practice Transformation Programme will undertake the following:

- **Workforce:** Analysis undertaken during 2018-19 has provided a GP practice workforce modelling tool that will assist in the development of a primary care workforce plan for Frimley ICS ensuring that the right people are available with the right skills at the right time. Modelling shows that without taking action there will be a “workforce gap” in our GP and nurse numbers. The focus during 2019-20 will be to attract people into (and back into) primary care and actively support the retention of existing staff. We will develop the **new primary care multi disciplinary team**, making the following workforce available to all GP practices: Paramedics, clinical pharmacists, advanced physiotherapists, mental health practitioners, advanced nurse practitioners, care navigators. In addition we will implement plans to recruit and **retain GP workforce** at both ends of their career and develop consistent **recruitment support tools** to be available for all GP practices. The building blocks to better support the workforce into posts and offer their training and development throughout their career will be agreed

- **Workload:** The current workload intensity in general practice is unsustainable and demand on primary care services is set to increase. Nationally general practice undertakes 90 per cent of NHS activity for 7.5 per cent of the cost, seeing more than 320million patients per year. Initiatives introduced during 2018-19 such as online consultations and document management training will be optimised across the Frimley system in order to improve practice efficiency, release clinical capacity and improve patient experience/self-care opportunities. Optimising the use of technology will improve services for our patients, enable increased self-management and release clinical capacity. Online activities will increase such as appointment booking and prescription ordering

- **Care Redesign:** Primary care networks build on core primary care services and provide a working relationship that may improve GP practice sustainability in the future. Working “at scale” across groups of practices will be a key area of care redesign during 2019-20. For patients, good access to their general practice is important and this will mean different things for different people. During 2019-20 local initiatives for improving the way patient demand for same day access is managed will be tested as part of informing the delivery of a more clearly articulated urgent care offering from general practice as part of its Primary Care Strategy.

- **Clinical Variation:** There is variation across general practice in a number of areas. The general practice work stream will be focusing on reducing clinical variation in three key areas learning disability health checks, vaccination and screening rates. During 2019-20 primary care will also participate in reducing variation in a number of other clinical areas and it will be important to manage the multiple requirements on general practice

- **Infrastructure** We will ensure that the interface with new digital and estates programmes is actively managed and includes strong primary care leadership
3. General Practice Transformation

**Deliverables**

For 2019-20 our focus will be on 1) **Maximising** and **optimising** the tools at our disposal to ensure general practice resilience and 2) **Building** and **developing** primary care networks.

**Workforce**
- Multidisciplinary workforce options will be available to all GP practices
- GP and nurse retention plans implemented
- Recruitment support tools available to all GP practices
- Implement a programme to support retention and development of non-clinical workforce
- Implementation of International GP recruitment programme
- Operationalisation of a demand and capacity tool which supports a more affective approach to workforce planning and management

**Workload**
- Reducing administration burden on GPs through workflow optimisation
- Increase options for patients to self manage through increasing usage of online consultations and other online services

**Care Redesign**
- Support the development of GP networks and optimise the benefits of “at scale” working in general practice.
- Develop a sustainable model for same day access to general practice services
- Agree a new model of mental health care in general practice

**Variation**
- Reduce current clinical variation in screening, immunisations and learning disability health checks
- Enhance depth of understanding of population needs and outcome variation through improved usage of data to support place based population health management
3. General Practice Transformation

How will services look by the end March 2020?
Patients will be able to access general practice at a wider range of times and by a wider range of routes. This will be achieved by increased appointment times including weekend and evenings and increased use of online tools such online consultations, appointment booking and prescription ordering. Patient will able to self manage more of their care and will find increased use of technology empowering. Patients will be able to receive their care from a wider range of health professionals in their general practice.

General practice workforce will be increased and developed and workload intensity reduced. This will include increasing the number of GPs by offering support and development opportunities to GPs within their first five years of working in general practice. GPs towards the end of their careers will also have access to opportunities which retain their skills. The general practice nursing workforce is a key component and they will be supported to increase their capability and capacity to deliver services differently and work in partnership with other health professionals. There will support and shared learning for the introduction of different healthcare professionals.

GP practices will be working together as part of a Primary Care Network, delivering a number of services to their local population at scale and GP practice, Network, CCG and ICS plans will all be aligned with common aims and objectives agreed. The future vision for the role of general practice will be developed and aligned to the ICS Strategic Plan produced in the summer of 2019. Recurrent funding and capacity will be agreed to support to the new role of networks in place based delivery and to create a sustainable workforce model for general practice that can meet current and future demands.

Outcomes and Benefits

Workforce
• Increased staff satisfaction with more staff retained resulting in a more sustainable workforce

Workload
• Optimised workflow and increased productivity within general practice
• Increased use of self management options for patients through online services

Care Redesign
• More patients who are satisfied with access to general practice (score in GP survey)
• More patients who describe their overall experience of general practice as ‘good’ (GP Survey)
• Improved patient experience with general practice services

Variation
• Contribution to a reduction in health inequalities for people with a learning disability
• Reduction in variation in MMR immunisation and cervical screening uptake

Key Risks and Mitigation
• General practice capacity to engage and lead required changes. This risk will be mitigated by reducing in duplication of effort (network role), investment in general practice workforce capacity, prioritisation across ICS programmes
• Lack of patient engagement in initiatives. Mitigated through communication being embedded within programme plans and a clear strategy to co-design solutions with practice populations
• General practice programme focussed internally and excluding the wider opportunities for transformation with secondary care and other community partners including local authorities. Mitigated through place based approach to local delivery with wider stakeholders
## 3. General Practice Transformation

### Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>3-28k</td>
<td>• Improved satisfaction with GP access&lt;br&gt;• Improved patient experience with GP services&lt;br&gt;• Increased use of self management options for patients through online services</td>
<td>• Increased staff satisfaction and retention resulting in a more sustainable workforce&lt;br&gt;• Optimised Workflow in general practice</td>
</tr>
<tr>
<td>Network</td>
<td>28-157k</td>
<td>• Reduction in health inequalities for people with a learning disability&lt;br&gt;• Reduction in variation in MMR immunisation and cervical screening uptake</td>
<td>• Optimised Workflow in general practice</td>
</tr>
<tr>
<td>System</td>
<td>1m+</td>
<td></td>
<td>• Reduction in size of workforce gap (GP and nurses)</td>
</tr>
</tbody>
</table>
3. General Practice Transformation

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus area</strong></td>
<td><strong>Retention scheme</strong></td>
<td><strong>WSGP implementation plan signed off steering group and initiated</strong></td>
<td><strong>Commence implementation across all Networks</strong></td>
<td><strong>End of year outcomes and benefits progress review</strong></td>
</tr>
<tr>
<td>Workforce</td>
<td>- Initiate “Next Generation GP Programme”</td>
<td>- WSGP implementation plan signed off steering group and initiated</td>
<td></td>
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</tr>
<tr>
<td>Increased staff satisfaction with more staff</td>
<td>- Project Initiation document for “Wise 5 GP (WSGP) support” project approved by steering group</td>
<td>- Initiation of phase 2 projects (focusing on maternity leave returns, advanced nurse training and practice manager development)</td>
<td></td>
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</tr>
<tr>
<td>retained resulting in a more sustainable</td>
<td>- Initiation of phase 2 projects (focusing on maternity leave returns, advanced nurse training and practice manager development)</td>
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<tr>
<td>workforce</td>
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<tr>
<td>Creation of new primary care workforce</td>
<td></td>
<td><strong>Sign off tools/guidance to initiate implementation plan</strong></td>
<td><strong>Quarterly reporting of workforce gap (on-going reporting)</strong></td>
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<tr>
<td>- Investment Case approved by ICS board</td>
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<tr>
<td>- Implementation plan signed off by GP steering</td>
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<tr>
<td>group.</td>
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<tr>
<td>- International GP Recruitment plan developed</td>
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</tr>
<tr>
<td>Workforce satisfaction</td>
<td></td>
<td><strong>Baseline survey completed in all practices</strong></td>
<td><strong>Survey results analysed and shared at GP Steering Group</strong></td>
<td><strong>Processes put in place for annual survey (Q2 2020-21)</strong></td>
</tr>
<tr>
<td>- All practices to agree to an annual system</td>
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<td></td>
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<tr>
<td>wide GP satisfaction survey</td>
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</tbody>
</table>
# 3. General Practice Transformation

## Milestones

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workflow Optimisation</strong></td>
<td><strong>a) Practice level (Phase 1)</strong></td>
<td><strong>b) Scale (Phase 2)</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Establish current % levels of documentation workflow by staff group across the ICS</td>
<td>• Sign off from the steering group of the target % shift of work load between clinicians/administrators</td>
<td>• Evaluation of outcomes/benefits presented and approved by Steering Group</td>
<td>• Further mobilisation and ‘at scale’ roll-out plan agreed by Steering Group</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Evaluation of outcomes/benefits presented and approved by Steering Group</td>
<td>• End of year evaluation of outcomes and benefits completed and reviewed by Steering Group</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Findings presented across Networks to identify spread opportunities</td>
<td>• Initiation of ‘at scale’ workflow optimisation</td>
</tr>
<tr>
<td><strong>Online Consultation</strong></td>
<td>• Establish baseline of current take-up Tranche 1 (T1) and usage across ICS</td>
<td>• (T2): Implementation plan initiated</td>
<td>• Evaluation of outcomes/benefits presented and approved by Steering Group</td>
<td>• End of year evaluation of outcomes and benefits completed and reviewed by Steering Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Next tranche of practices identified (T3)</td>
<td></td>
</tr>
<tr>
<td><strong>GP Online Services</strong></td>
<td>• Establish baseline of current take-up of GP Online Services</td>
<td>• Steering group signs off Implementation plan</td>
<td></td>
<td>• Evaluation of outcomes and benefits completed</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Framework and lessons learned documentation formulated, signed off, handed to BAU and next tranche (Networks)</td>
</tr>
</tbody>
</table>
## 3. General Practice Transformation

### Milestones

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Redesign</td>
<td>• Network year 1 development plans and funding developed and agreed (in line with NHS Long Term Plan and existing maturity of Networks)</td>
<td>• Lessons learned from Network delivery plans collated and reviewed for sharing and spread</td>
<td>• Network development progress reviewed at Steering Group</td>
<td>• Networks’ planned delivery of outcomes and benefits assessed</td>
</tr>
<tr>
<td></td>
<td>• Existing Network level delivery plans and resourcing developed in 2018-19 signed off</td>
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<tr>
<td></td>
<td>• GP Steering Group signs off network pilots to improve same day access for 0-5 year olds</td>
<td>• Outcomes, benefits and lessons learned from Network delivery plans collated and reviewed for sharing and spread</td>
<td>• GP Steering Group agrees articulation of urgent care offer from general practice</td>
<td></td>
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<tr>
<td></td>
<td>• Cross programme measures of success (GP survey metrics) agreed</td>
<td>• GP Survey completed by all practices</td>
<td></td>
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</tr>
<tr>
<td>Clinical Variation</td>
<td>• Project Scope at a network level defined</td>
<td>• Implementation plan initiated across all 10 Networks</td>
<td>• Realisation of outcomes and benefits approved by Steering Group</td>
<td>• Recommendations embedded in Networks and moved to business as usual</td>
</tr>
<tr>
<td></td>
<td>• Interventions confirmed between Public Health and Networks</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>• Project plan formulated and signed off by Steering Group</td>
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</tr>
</tbody>
</table>
4. Support Workforce

**Aim**
This initiative aims to design a support workforce that is fit for purpose across the ICS system. We will deliver a clear understanding of the number and skills of the support workforce required to deliver the Frimley ICS vision for integrated care and improved prevention. As an enabling work stream, the key objective will be to develop the capability and capacity of the support workforce in the independent sector, local authorities and health. The focus will be on reducing turnover, increasing overall workforce capacity and developing a workforce with the skills to support integration and enable people with complex needs to stay in their own homes for longer.

**Description**
Over 15,000 support workers are employed by health and social care providers across the footprint. Making up over 60% of total ICS workforce assets, a capable and competent workforce able to work across care settings is an essential enabler to the Frimley system priorities particularly long term conditions (LTC), frailty management, improved prevention and self care. The Frimley system workforce strategy identified that implementing new models of care will drive demand growth in the support workforce by around 1,000 full-time equivalents. This will be required to underpin the activity shift from acute care (which requires a workforce with a high proportion of advanced skills) towards a focus on prevention and early intervention (where a greater level of activity can safely be delivered by trained support workers). For example, workforce modelling for Integrated Care Decision Making (ICDM) process has identified the requirement to increase the generic (support worker) workforce providing care and support by up to 50%.

The majority of the Frimley system support workforce work is in adult social care (mainly in the independent sector). Overall this sector struggles to recruit and retain care workers. Contributing factors include competition from other industries and the negative image of working in the care sector partly linked to a perceived lack of career opportunities. To address this during 2019-20, we will focus on the implementation, evaluation and spread of products to enable workforce growth and integrated working:

- Strategies to attract new workers through a joint approach to recruitment linked to a communications strategy to highlight the benefits of a career in health and care
- Career pathways linked to apprenticeships to improve recruitment and retention and build capacity
- Supporting integration by the development of a workforce with skills that span health and social care boundaries
- Develop a suite of training that will support, develop and retain staff within the system
- Increase the opportunities to attract volunteers to support our workforce.

As these initiatives gain traction, our focus will need to move toward up-skilling the support workforce in primary care and integrated care decision making teams to build capacity and address skills gaps.
4. Support Workforce

**Deliverables**
- An agreed process for cross sector secondments to build capacity in the adult social care sector
- A learning and development passport which enables movement between sectors and promotes an integrated approach to training
- Working in partnership with Skills for Care Solutions Ltd to develop and embed an enhanced care worker role to enable improved community provision for the frail elderly and those with complex needs
- The development of tools, workforce models and employment approaches to support and enable partner organisations across the NHS, Local Authorities, Independent and voluntary sector to manage, recruit and develop their workforce
- A full review of Human Resource practice across the ICS to enable cross organisation working, this will include: terms and conditions, contracts, remuneration, induction etc.
- The development and implementation of integrated apprenticeships to rotate across both Health and Social Care providers
- Develop a Stakeholder engagement strategy working with the Care Provider Associations and other providers
- A Stakeholder programme for the year what is going well what else do we need to do to support the delivery
- Develop the market intelligence around workforce to include information on staff experience, turnover, and themes from exit interviews to inform on future development
- Create a suite of tools to support recruitment the development and retention of staff across the ICS

**Outcomes and Benefits**
- Improved quality of care in care homes for people with complex needs by providing a stable social care workforce
- Improved capacity within the community workforce will help to prevent admission and reduce delayed transfers of care
- Increasing the capacity of the primary care workforce will improve the management of long term conditions helping to prevent crisis and ultimately lead to reduced A&E activity
- Empowering staff to recognise signs of deterioration in individuals and escalating when appropriate to deliver personalised care
- Increased number of volunteers to support the workforce and carers within the system
- Staff are able to move and work within the ICS with an electronic record of training

**Key Risks and Mitigation**
- The workforce strategy anticipates the need to recruit over 1000 new support workers to underpin new ways of working. The local area has very low rates of unemployment and high wages resulting in strong competition for workers for other sectors. In order to mitigate this risk, we will hold joint recruitment events to attract people to work in the health and care sector. We will also develop a communications approach that emphasises the advantages of working in the health and care sector to address negative perceptions.
4. Support Workforce

How will services look by the end March 2020?

The impact of this work stream is across the Frimley Health and Care ICS population.

The support workforce makes up over 60% of the total ICS workforce assets and is an essential enabler to delivery of the ICS priorities. Priorities are working towards a stable, valued, appropriately skilled support workforce, provided with career development opportunities.

Developing staff using structured approaches like the Stop Look Care programme, allows support Care Workers/Carers who work in a registered service recognise changes in an individual’s condition by monitoring them and or recognising any deterioration in a person’s wellbeing, increases awareness when to refer on when appropriate. It also supports an increase in confidence in the support workers and introducing the building blocks of increasing flexibility/blurring of skills between health and social care staff’.

As the demand for health and care services becomes more complex, and the lines between health and care organisations become more blurred, the ICS vision is for developments that are place-based and not service, organisation or condition-based.

By establishing services that bring together partners from all sectors we will adopt a common approach to managing the needs of individuals living with complex needs, frailty and multiple physical and mental health conditions. This integrated approach will help to pro-actively manage the conditions of patients and residents, empowering them to maintain their independence for longer through the provision of wrap around support to meet their needs.

This proposal will be key to developing a workforce with the skills to work either in, or in partnership with, integrated teams to deliver health and care intervention to our population.
### 4. Support Workforce

#### Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood</td>
<td>~50k</td>
<td>• Improved patient satisfaction/experience through receipt of personalised care</td>
<td>• Improving capacity within the community workforce will help to prevent admission and reduce delayed transfers of care</td>
</tr>
</tbody>
</table>
| Place       | ~250-550k | • Improved quality of care in care homes for people with complex needs by providing a stable social care workforce | • Increasing the capacity of the community care workforce will improve the management of long term conditions helping to prevent crisis and ultimately lead to reduced A&E activity  
• Increased number of volunteers to support the workforce and carers within the system |
| System      | 1m+       |                                                                          | • Staff are able to demonstrate that they have completed mandatory and statutory training using a digital record when working within the ICS improving staff satisfaction and opportunities to work across the ICs |
## 4. Support Workforce

### Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alignment of interfaces with other workstreams completed</td>
<td>• Recommendations for capturing Mandatory and Statutory Training (MAST) across the ICS developed</td>
<td>• Digital ICS MAST/Passport implemented</td>
<td>• Passport system evaluated Stakeholders programme evaluated</td>
</tr>
<tr>
<td>• Current training systems evaluated</td>
<td>• Apprenticeship scheme Q2 Review completed</td>
<td>• Workforce model project scoped</td>
<td>• Audit outcomes implemented following staff surveys and exit interviews</td>
</tr>
<tr>
<td>• Identify a programme of support for Stakeholders to assist with recruitment and retention</td>
<td>• Action plan developed to support stakeholders</td>
<td>• Secondments evaluated</td>
<td>• Workforce model evaluated</td>
</tr>
<tr>
<td>• Workforce review completed and areas for development identified</td>
<td>• Staff experience/exit interviews audited</td>
<td>• Apprenticeship scheme Q3 review completed</td>
<td>• Framework developed for assessment of competencies for champions of Stop Look Care</td>
</tr>
<tr>
<td>• Secondment process reviewed across the ICS with recommendations identified</td>
<td>• Stop Look Care implemented</td>
<td>• Stakeholder engagement strategy finalised with working Care Provider Associations</td>
<td>• Apprenticeship scheme Q3 review completed</td>
</tr>
<tr>
<td>• Recommendations for workforce models reviewed and approaches to recruitment developed</td>
<td>• Process for cross sector secondment agreed</td>
<td>• Process for cross sector secondment implemented</td>
<td>• Passport system evaluated</td>
</tr>
<tr>
<td>• Implementation plan developed for Stop Look Care</td>
<td>• Process for cross sector secondment implemented</td>
<td>• Toolkit developed to support recruitment</td>
<td>• Stakeholders programme evaluated</td>
</tr>
<tr>
<td>• Stop Look Care coordinators appointed</td>
<td>• Stop Look Care framework published</td>
<td>• Stop Look Care implemented</td>
<td>• Review completed of the requirements for Industry placements as part of the new Health and Social Care T levels for 16-18yr olds</td>
</tr>
<tr>
<td>• Apprenticeship scheme Q1 review completed</td>
<td>• Review completed of the requirements for Industry placements as part of the new Health and Social Care T levels for 16-18yr olds</td>
<td>• Audit outcomes implemented following staff surveys and exit interviews</td>
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</table>
5. Care and Support Market

Aim
This programme aims to shape a care and support market that is sustainable and fit for purpose across the system for the future. It will do this by developing and embedding a commissioning culture that creates a sustainable care and support market that is responsive to demand and which specifically addresses equity of price, capacity, capability and quality at a system level. With ICS partners, the programme aims to enhance the quality of care and support provided in residential settings; develop a culture of collaboration between commissioners and providers for procurement of complex placements; research and recommend new care options and future initiatives around personalised and alternative care; and work together on an accommodation with care strategy. Taking a whole market approach, the programme will also work with self-funders on prevention and awareness of care and support options.

Description
This programme is focused on the independent care and support market operating within the ICS boundary. The programme addresses the growing needs of our population (an ageing population but also an increasing number of people with disabilities) by working in partnership with providers and local residents on the integration of health and social care services to address efficiency, innovation and the need for a greater focus on prevention and choice. We are working together to co-design a sustainable model of care and support which enables people to continue living at home for as long as possible, only going into hospital or a residential setting when essential to their care and support needs. We will achieve our aim by:

- Developing and embedding a commissioning culture that creates a sustainable care and support market that is responsive to demand and which specifically addresses equity of price, capacity, capability and quality at a system level
- Co-designing a clear statement of intent to transform the way care and support is commissioned within the ICS, and improve the planning of care to ensure the market is ready to meet the future needs of individuals
- Enhancing the quality of care and support provided in residential settings, working alongside existing providers to set an ambitious but achievable benchmark for the ICS’s expectations of good quality care
- Developing a culture of collaboration between commissioners for procurement and purchasing of care and support needs and especially of complex placements, ensuring that individuals in high cost placements are regularly reviewed to ensure value for money
- Researching, reviewing and recommending new care options and future initiatives around personalised and alternative care, including the further development of direct payments to empower individuals to exercise control and choice in how their care is delivered
- Developing an accommodation with care strategy in partnership with Local Housing Authorities to ensure that the ICS housing market can meet future demand and minimise cost pressures for all parties
- Taking a whole market approach, working with self-funders on prevention and awareness of care and support options
- Working in collaboration and co-design with care providers across the ICS
5. Care and Support Market

Description

Our programme components include:

- Supporting people with diverse care and support needs to maintain their independence at home
- Transform perceptions of the levels of care and support provided in residential settings to being primarily for people with highly complex needs, and to be considered only when other options cannot safely meet the individuals’ need
- Ensuring people do not stay longer than they need to in hospital, and supporting effective discharge with seamless return home
- Commissioning personalised care which is community-focused, managed for quality and sustainability and evolving to match future population needs
- Establishing a more collaborative approach to commissioning care and support across the ICS partners
- A clear co-production approach across all of the projects of the programme

We have identified the following key areas of focus for 2019-20 which build on our successes to date, and takes us closer to the realisation of the programme aims and objectives:

- Working collaboratively with the independent care sector to ensure there is a sustainable care and support market across the ICS whilst ensuring there is choice and quality of service for our residents
- Developing a culture of unity and co-design with the independent sector, encouraging conversations on prevention, choice and quality rather than just commerciality
- Working together across the ICS to align our commissioning and procurement approaches for consistency and greater efficiency – especially in relation to placement costs, and to increase our leverage with the market for services that support our vulnerable adults
- Harnessing the influence of collaborative commissioning of complex and high cost placements, ensuring that we are achieving the best quality care at the most appropriate price for equity across the ICS
- Developing an ICS accommodation with care strategy 2020-2035 to develop new models of care and support to meet the needs of our population for the future
- Improving the GP and primary care support provided to people living in care homes
- Reviewing the new models of care/domiciliary care/community care being developed across the country – including wellbeing teams, use of technology/digital - and evaluate effectiveness and impact and suitability/approach for our system
- Aligning the work of this programme with other ICS programmes especially the Support Workforce programme
Deliverables

The key deliverables for 2019-20 are:

- Develop the key principles for collaborative commissioning across the ICS partners to support a sustainable market in co-production with people who use services and providers
- Publish the ‘a message to the market’ – to supplement and support each partners market position statements and with clarity of future ambition and priorities
- Share intelligence to support both strategic and granular placement and pricing for care and support including direct payments and support to self-funders
- Create an ICS wide strategy for accommodation with care that reflects local demand and makes best use of supply options across the ICS boundary
- Bring to market, in collaboration with providers, an Enhanced Care Worker role to operate in provider settings across the ICS, supporting supply and demand across health and care settings, including in domiciliary, intermediate and long term residential care
- Develop a plan for enhancing the support of primary care and GP support to care homes through multi agency working to the independent sector, and developing an implementation plan with measurable milestones for delivery
- For staff within the ICS to hold the competencies required to undertake verification of expected death
- Empowering the staff to recognise signs of deterioration in individuals and escalating when appropriate to deliver personalised care
- Greater connection of Health and Social care providers with these of NHS.net

Outcomes and Benefits

- Contribute towards a system objective to reduce acute admissions from care homes by 12% by end of March 2020
- Contribute towards a system objective to reduce the length of stay in hospitals from care homes by 8% by end of March 2020
- Consistent Integrated support to care homes from Primary care using a Multi Professional approach reducing hospital admissions and length of stay
- Staff are competent in identifying and taking action on deterioration in needs and supporting personalised care
- Reduce medicines wastage to secure savings of approx. £400k during 2019-20 (subject to CCG funding from April 2018)
- No increase in admissions to care homes until end of March 2021 (ASCOF)
- Achieve cost saving of around £1m on individual placements and support packages by end of March 2021

Key Risks and Mitigation

- Engagement of all stakeholders in the footprint – a communications and engagement plan supports this
- Agreement in alignment of commissioning structures and models – work with providers to co-design the approach
- Pace of the project is slow due to the complexities – focus on co-designing the approach
- Lack of authority to make decisions – involvement at the right level and escalation process
- Demand increasing beyond budget levels and local capacity levels – integration and innovation
How will services look by the end March 2020?

- The shared aims and priorities of the Frimley Health and Care ICS will be delivered by adopting a more collaborative and integrative approach between the commissioners and providers across the system
- Partners in the ICS will be working collaboratively to commission and deliver services on and behalf of each other and also partners commissioning on behalf of each other to meet the needs of our older and disabled people
- The ‘message to the market’ with the ambitions for meeting the needs of older and disabled people across the Frimley system will be understood and embedded
- A plan will be in place to deliver a range of new accommodation with care and support options to meet the needs of our older and disabled population for the next 15 years
- A plan will be in place to meet the care and support needs of people with the most complex needs closer to home
- The quality of the range of our local providers will be good or outstanding
- Councils and CCG’s will be working alongside care providers to ensure that value for money and financial sustainability is delivered across the system
- A consistent and good quality health support to people living in care homes will be in place
- Good advice for self funders to make good and informed decisions about their care needs

As a result individuals and carers will feel supported and listened to receiving high quality care in their own homes for as long as they can before (if needed) moving to an appropriate care in order to meet their needs:

- People working in care and support services will have a higher quality of experience with access to training to enhance their skills
- People accessing care and support services will have a higher quality of experience (ASCOF measure)
- A wider range of care and support options will be available and awareness of options will be increased, with a greater focus on personalisation
- Support from primary care and health professional to prevent admissions to hospital from care homes
- Reduced length of stay in a hospital from care home residents and improvements in delayed transfers of care (DTOCs)
## 5. Care and Support Market

### Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| Neighbourhood | ~50k      | • People with complex needs will have their care and support needs met   | • Staff are competent in identifying and taking action re deterioration in needs and supporting personalised care  
• Achieve cost saving of around £1m on individual placements and support packages by end of March 2021 |
| Place       | ~250-550k |                                                                            | • Consistent Integrated support to care homes from primary care using a Multi Professional approach reducing hospital admissions and length of stay  
• No increase in admissions to care homes until end of March 2021 (ASCOF) |
| System      | 1m+       |                                                                            | • Contribute towards a system objective to reduce acute admissions from care homes by 12% by end of March 2020  
• Contribute towards a system objective to reduce length of stay in hospitals from care homes by 8% by end of March 2020  
• Reduce medicines wastage to secure savings of approx. £400k during 2019-20 (subject to CCG funding from April 2018) |
5. Care and Support Market

### Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collaborative and integrative commissioning approach agreed</td>
<td>• Lead commissioner appointed to establish accommodation with care programme</td>
<td>• Governance arrangements confirmed</td>
<td>• Joint Commissioning Strategy and Plan developed and agreed</td>
</tr>
<tr>
<td>• Agreement to progress on a joint approach towards commissioning housing and accommodation with care for older people</td>
<td>• NEWS App options appraisal completed</td>
<td>• Review completed and implementation in place from audits as part of the medications optimisation programme</td>
<td>• Evaluation of ICS medicines optimisation team work</td>
</tr>
<tr>
<td>• NEWS (national early warning scheme) training delivered to all care homes to identify the deteriorating patient and reduce admissions</td>
<td>• Review medicines waste management metrics completed</td>
<td>• Alignment of the commissioning and procurement approaches for consistency and greater efficiency</td>
<td>• Initiation of Wellbeing Teams model</td>
</tr>
<tr>
<td>• GP and primary care models reviewed for people living in care homes</td>
<td>• NHS.net Mail in place in care homes</td>
<td>• Options appraisal completed regarding initiatives for personalised and alternative care and development of direct payments</td>
<td>• Self funders support in place</td>
</tr>
<tr>
<td>• Hydration project evaluated and its impact on emergency admissions determined</td>
<td>• New models of care/domiciliary care/community care reviewed</td>
<td>• Communication plan in place for support and care options and capital threshold awareness for self-funders</td>
<td>• Whole market approach to self-funder coordinators agreed</td>
</tr>
<tr>
<td>• Medicines management audits completed</td>
<td>• Options appraisal completed regarding future initiatives for personalised and alternative care and development of direct payments</td>
<td>• Implementation plan for personalisation in place</td>
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<tr>
<td>• Review of quality of care provided in residential settings completed</td>
<td>• Communication plan in place for support and care options and capital threshold awareness for self-funders</td>
<td>• Whole market approach to self-funder coordinators agreed</td>
<td></td>
</tr>
<tr>
<td>• Shared negotiation approach agreed between commissioners and providers</td>
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<td>• Implementation plan for personalisation in place</td>
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<td>• Personalisation project scoped</td>
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<td>• Self funders project scoped</td>
<td>• Personalisation project scoped</td>
<td>• Implementation plan for personalisation in place</td>
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<tr>
<td>• Care provider support arrangements in place</td>
<td>• Personalisation project scoped</td>
<td>• Whole market approach to self-funder coordinators agreed</td>
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</tr>
</tbody>
</table>
6. Reducing Clinical Variation

**Aim**
The aim of this initiative is to improve health outcomes and maximise value for our patient population through the reduction of variation in clinical practice across the ICS. Using the NHS RightCare data and intelligence as a starting point, we will use a wide source of data interpreted under local conditions to target resources in the areas that will achieve the greatest value. Consistent with other transformation programmes, the Reducing Clinical Variation programme adopts an evidence-based, clinically-led approach to ensure that newly designed services and clinical pathways adopt best-practice to reduce unwarranted variation whilst improving patient outcomes and quality in a way that is financially sustainable. ICS partners aim to improve to their understanding and ability to address the variation in quality outcomes and the true system costs relation to them.

**Description**
The overall objectives are as follows:

- To provide patient outcome focused care to our population across the ICS through the identification of unwarranted variation in clinical practice
- To use nationally collected data, interpreted in a local context, to identify best practice models of care that can be adopted locally in a way that improves health outcomes for our patients
- To identify, understand and address root cause effect of health inequality for our population
- To drive service and pathway re-design through strong clinical leadership and in a way that engages our population in a meaningful way, empowering them to take greater ownership of their care throughout the pathway
- To provide a better patient experience closer to home offering a more pro-active approach where this adds value to the patient
- To reduce the level of unplanned care undertaken within the system as patients are managed in a more pro-active manner through a planned care pathway
- To reduce costs to the system which accrue as a result of inefficient deployment of resources where unwarranted variation exists

The Reducing Clinical Variation program is ultimately aimed at providing evidence based outcome focused care to our population across the Frimley system. We are clear that it is unacceptable to provide inconsistent care to our patients that leads to differing quality and health outcomes. We will focus on identifying pockets of inconsistency and addressing the issues through the design of new services and pathways that ensure that the best possible care is delivered to our patients in the most efficient way possible. It is essential that our patients are able to access the right care, in the right way at the right time.

In order to identify the right areas to focus on, we have accessed the NHS RightCare data and public health data in tandem as a starting point for our local discussions and plans. NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, improving patient outcomes and gaining true value for money. Consistent with the aims of the programme, NHS RightCare seeks to improve health outcomes across populations by addressing unwarranted variations in clinical practice. Public health information is critical as a partner to the other data sources as it supports the reduction of health inequalities in very local places within our geography as well as generally raising the standards for all.
6. Reducing Clinical Variation

**Description**

The value of the NHS RightCare programme is the national benchmark data it provides. We have localised this data and data packs have been developed for all of our CCGs across the ICS. We have identified that our main opportunities are in enabling specific cohorts of patients with long-term conditions rapid access to relevant services. Our work in 2019-20 builds on the learning and developments made in 2018-19 and shifts focus from addressing service delivery to defining outcomes and “value” for our residents. To that end we will focus on early intervention with patients having the resources and expertise to self-manage where ever possible, supported by the right clinicians. Also, through supporting our patients to be pro-active in their care and make better lifestyle choices rather than adopting a reactive philosophy, we will move patients along the care pathway; away from unplanned care to more timely and effective planned care interventions. Our programme of work includes the following pathways:

- **Musculoskeletal (MSK):** This is a two phase programme. Phase 1 commenced in 2017-18 focusing on osteoarthritis, pain and falls. By using a whole system approach we are working to improve the primary care osteoarthritis pathway incorporating demand management and high impact interventions identified in the NHS England MSK handbook. We have established masters classes based in the community providing people with a deeper understanding of their condition and alternative ways of managing. Over a rolling year, 40% of patients who attended a master class did not proceed to surgery with a 99% patient satisfaction rate. Phase 2 will focus on identifying further transformation in line with national initiatives such as developing integrated MSK services.
- The pain pathway across the ICS will be redesigned with implementation in 2019-20. This will include alignment across the ICS of PLCV principles through a centralised triage approach. The falls work will be delivered in consideration with the wider ICS agenda linked to frailty and integrated hubs.
- **Circulatory:** This work is focused on improved management of all cardiac conditions in a local and accessible way for the patient, through pro-active case finding and signposting to the right service, first time. We will develop standardised interventions and pathways across the system and provide quality rehabilitation and support services. The improvements from the re-design of the chest pain and heart failure pathways shall be evident through 2019-21. Through the application of new technology (CT-FFR) we continue to improve diagnostics for suspected angina to reduce the need for invasive angiography. We have already seen a 13% reduction in non value added angiography. The new Rapid Access Suspected Angina Clinic and pathway work in collaboration with an improved referral approach in primary care will reduce the number of non-cardiac patients referred to the pathway, ensure timely commencement of medication helping to reduce the risk of Acute Coronary Syndrome or Myocardial Infarction and identify the appropriate patients for further investigation and treatment.
- **Gastro-Intestinal:** This work is two fold. Project 1 aims to redesign services focusing on a standardised central referral point with integrated primary and secondary services, rapid access to triage and diagnostics, and signposting patients to the right service, first time. Project 2 focusses on screening for, identifying and then managing an emerging burden of disease around Non Alcoholic Fatty Liver disease.
- **Neurology:** We are implementing a new integrated neurology service across the system. The service will provide seamless, patient focused, pro-active and reactive support which will enable patients to live as independent as possible in their own homes. This will reduce variation and increase equality across the system by providing local integrated population based services.
6. Reducing Clinical Variation

Description

• **Respiratory:** We are focusing on supporting primary care identification of patients with or at risk of developing COPD or asthma. We are reviewing how prescribing and use of latest technology can be optimised across the ICS to support patients to take greater ownership of their condition. We are working across agencies within the system to deepen our understand of how patients engage and interact with our services and the outcomes they receive. This will inform our approach to an integrated respiratory service across the ICS and validate the decisions made

• **Diabetes:** Continue the successful delivery and implementation of structured education courses, to reduce variation across the ICS and maintain improvement from 20%. Improve the achievement of HbA1c, cholesterol and blood pressure treatment targets from 42% and second best nationally. Improve the timeliness of referrals from primary care to a multi-disciplinary diabetic foot team (MDFT) and increase the provision of inpatient Specialist Nurses

How will services look by the end March 2020?

Patient experience:

• Our patients and residents will feel involved in the development of our program so that the patient voice remains strong and shapes the work being done

• Our patients will be central to and inform our understanding of “value” and what this means to them. We will enable the environment and connections between system partners to support this recognition and understanding with patients at the heart of the discussion

• Our patients and residents will have greater understanding of their condition in line with those which our program prioritise

• Our patients and residents will see the shift of resource which provides localised more accessible solutions to them in their local community

• Our patients and residents will feel informed and knowledgeable about the local resources available to them which can be easily navigated when needed

• Our patients and residents will be supported and feel empowered to build the resilience and structure of their local communities including all partner organisations so that health and social care work in conjunction, responding to the needs of the whole person

• Our patients and residents will benefit from early detection and intervention to enable better outcomes

• Our patients and residents will feel informed and knowledgeable about the local resources available to them which can be easily navigated when needed

Staff experience:

• We shall work with integrity so that our staff are considered, consulted and listened to as we work to deliver a flexible and responsive approach to service delivery

• We shall develop our staff equipping them with the best and most appropriate skills for the roles they fill whilst enabling them to be adaptable and flexible in the way they work within the health system

• We will build the infrastructure to support interoperable working of our teams across organisations
6. Reducing Clinical Variation

**Deliverables**
We are working to achieve specific service improvements and reduction in clinical variation across the five areas through:
- Local population based operational and delivery mechanisms which will reduce inequity across the system
- Consistent, standardised disease specific pathway development across providers with rapid access to general and specialist diagnostics
- Early identification and pro-active care through case identification and risk stratification
- Locally delivered integrated community services with standardised service delivery models and service specifications
- Structured self-management and care educational programmes
- Structured educational programmes for patients and General Practitioners across the ICS
- Access to seamless care pathways through case management and targeted support systems for all patient groups across all specialties
- Comprehensive data sets across each of the focus areas by CCG and across the ICS
- To increase the use and interoperability of technology as an accessible interface for patients in the management and delivery of their care
- Support equal access to diagnostics across the system

**Outcomes and Benefits**
- Patients receive optimised treatment consistently resulting in improved health outcomes:
  - Diabetes: Over 50% patients achieving three treatment targets by 2019-2020, currently at 47%
  - MSK: Increase in 40% of patients who attended the Versus Arthritis master class not proceeding to surgery with a 99% patient satisfaction rate
- Improved patient satisfaction with services - baselines currently being measured
- Patients receive proactive integrated services for individuals resulting in improved health outcomes. Specific to the education programmes provided within primary care by both Respiratory and MSK groups with a focus on mapping impact of early intervention and any corresponding secondary care activity
- Patients using self management options resulting in improved outcomes
- Financial benefit - reduction in elective and non-elective care spend with improved demand management:
  - COPD non-elective activity remaining at baseline levels
  - 35% reduction in average length of stay for non elective patients with a diabetic exacerbation
- Reduce elective surgical spend for Orthopaedics compared to baseline

**Outcomes and Benefits**
- Financial benefit - reduction in number of clinical appointments needed and non value added diagnostics undertaken
  - Reduce outpatient first appointments (OPFU) and outpatients follow ups (OPFU)
  - CVD: 13% reduction in angiography, 24% reduction in echocardiogram

**Key Risks and Mitigation**
- Construction of data across the ICS to determine variation. This risk will be mitigated by using a combination of local data flows using Connected Care as well as NHS RightCare and national datasets
- Lack of engagement across primary and secondary care. This risk will be mitigating by gaining sign up from across the system and relevant clinicians feeding into the work stream, continued engagement and agreed principles and specific actions jointly developed
- Focus on disease areas does not reduce variation. This risk will be mitigated by employing the NHS RightCare approach and consistent development of care pathways across the system and continued monitoring of data to assess impact
## 6. Reducing Clinical Variation

### Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| **Neighbourhood** | ~50k      | • Patients receive optimised treatment resulting in improved health outcomes  
• Use self management options resulting in improved outcomes |                                                                                                     |
| **Place**     | ~250-550k | • Increased patient satisfaction of specified groups  
• Patients receive optimised treatment resulting in improved health outcomes | • Financial benefit with reduced non-elective / elective activity, length of stay, and increased repatriation rates |
| **System**    | 1m+       | • Improved patient satisfaction with use of virtual technology, Versus Arthritis programme and Shared Decision Making  
• Patients receive optimised treatment resulting in improved health outcomes | • Financial benefits of reduced clinical appointments and use of diagnostics |
## 6. Reducing Clinical Variation

### Milestones

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td>Optimised treatments and health outcomes</td>
<td>• Achieve &gt;50% of patients attending structured diabetes course</td>
<td>• Achievement of diabetes target maintained</td>
<td>• Achievement of diabetes target maintained</td>
<td>• Achievement of diabetes target maintained</td>
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<tr>
<td></td>
<td>• Evaluation completed on workforce recruitment invested during 2018-19</td>
<td>• Complete Q2 evaluation report on outcomes impact – reviewed by steering group</td>
<td>• Completed Q3 evaluation report on outcomes impact – reviewed by Steering Group</td>
<td>• Completed Q4 evaluation report on outcomes impact – reviewed by steering group</td>
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<tr>
<td></td>
<td>• Data gathering initiated for respiratory patients; impact of early intervention, secondary care outcome and population health demographic data mapped</td>
<td>• Lessons learned exercise undertaken across work streams</td>
<td>• Continuation of data gathering for Respiratory services.</td>
<td>• Lessons learned exercise undertaken across work streams</td>
</tr>
<tr>
<td></td>
<td>• Achieve &gt;50% of patients on three treatment pathways for diabetes by end Q1</td>
<td>• First evaluation of Respiratory data completed</td>
<td>• Diagnostic strategic plan implemented</td>
<td>• Evaluation of Neurology service implementation completed</td>
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<tr>
<td></td>
<td>• New technologies embedded across work streams; opportunity for telemedicine, enhanced DXS offer, advice and guidance and patient education and self management app technology reviewed</td>
<td>• Initial planning approach for Respiratory outlined</td>
<td>• Outline plan and model of delivery scoped for functional disorders</td>
<td>• Second evaluation of respiratory data completed</td>
</tr>
<tr>
<td></td>
<td>• Lessons learned exercise undertaken across work streams</td>
<td>• First phase Respiratory changes initiated</td>
<td></td>
<td>• Next Respiratory planning approach defined</td>
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<tr>
<td></td>
<td>• Strategy for improvement in diagnostic capacity and demand management identified</td>
<td>• Diagnostic strategic plan endorsed through wide stakeholder engagement</td>
<td></td>
<td>• Diagnostics review completed</td>
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<tr>
<td></td>
<td>Improved patient satisfaction with services</td>
<td></td>
<td>• Implement virtual technology and measure</td>
<td></td>
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<tr>
<td></td>
<td>• Virtual interactions approach developed for GI, Cardiovascular (CVD), MSK</td>
<td>• Implementation plan for virtual technology for MSK, GI and CVD finalised</td>
<td>• Implement virtual technology</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• patient satisfaction rates and behavioural changes through technology use for GI measured</td>
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<td>• Learning reviewed for adoption for other pathways</td>
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6. Reducing Clinical Variation

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ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR
## 6. Reducing Clinical Variation

### Milestones

<table>
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<tr>
<th>Outcome</th>
<th>Q1</th>
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<th>Q4</th>
</tr>
</thead>
</table>
| Proactive integrated services with improved health outcomes | • Strategy and approach to patient engagement agreed across the work streams  
• Patient Voice session held to test response to initiatives | • Impact of shared decision making pilot evaluated from patient perspective | • Patient engagement event held for weight management approach within secondary prevention relevant to all condition groups | • Annual review of patient engagement initiated |
| Use of self management options resulting in improved outcomes | • Pilot for shared decision making initiated  
• Engagement with stakeholders completed  
• Approach to shared decision making developed across all programmes | • Impact of shared decision making pilot evaluated | • Long term approach to shared decision making outlined and proposed | • Implement approach to shared decision making at larger scale  
• Measure impact against baseline both qualitative and quantitative |
| Reduction in elective and non elective spend, improved demand management | Q1 report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend | Q2 report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend | Q3 report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend | Q4 report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend |

**Q1** report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend  

**Q2** report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend  

**Q3** report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend  

**Q4** report completed for programme metrics including:  
• Reduction in NEL activity across work streams  
• Reduction in EL admitted spend and surgical interventions across work streams  
• Reduction in GP referrals to specialist and volume of OPFA and OPFU  
• DC and OPPROC spend
7. Shared Care Record

**Aim**
The strategic vision is to continue to develop a digital ecosystem that is driven by clinical, operational and transformation to support information being available to healthcare professionals at the point of care. The key enabler to this - Connected Care will support information being available to healthcare professionals in their own clinical system. Functional enhancements will be informed and co-designed by the shared record group. We will also enable residents to view and contribute to a Person Health Record (PHR) and this will all be underpinned by an intelligence platform that will support strategy and care professionals.

**Description**
A shared record platform (Connected Care) has been deployed across the Frimley system and is a key enabler for the other ICS programmes and organisational transformation programmes. It was formed in response to residents saying that care could be better coordinated, and they only wanted to tell their story once. The resulting digital programme will have the majority of organisations providing information into a shared information repository and being able to view information at point of care. A key objective is to embed a link to Connected Care within current digital systems in order to maximise ease of access for care professionals. We have developed a professionally led design programme to enhance the value of Connected Care to our care professionals and residents.

This initiative will maintain and enhance the value to care professionals by making iterative improvements to the existing system, by capturing clinically led change from professionals across the ICS and translating these into a technical specification. Health and social care professionals from across all organisations work collaboratively to deliver improvements to Connected Care, based on feedback from user and clinically led design. This encapsulates shared language and shared agreements around key information sets, which will lead to better informed, more timely decision making at the point of care for our population. Key benefits will be realised through baseline information being made available to care professionals through a Frimley ICS designed module called Daily Life and the ability to capture shared decisions for forward planning.

A key priority is to deliver a person facing platform which will put residents at the centre of their care in order to promote greater self-care and wellbeing. By providing residents with targeted information, active signposting and utilising online support tools, we aim to support residents take greater ownership of their wellbeing and empower them to keep well. In addition to wellbeing, we will provide the capability for residents to capture feedback to better understand patient experience and outcomes that are important to residents. The person health record will also support to improve resident experience by aggregating appointments from health and care, simplifying consent and opt out and supporting greater transparency about how we use resident information.

Underpinning all of the above is a single Intelligence platform that will be linked to the person health record that will allow analytics and insight to be derived on behalf of ICS priorities.
7. Shared Care Record

**Deliverables**

### Technical Feeds
- Statutory organisations that are partners within Frimley ICS will be contributing to and viewing information within Connected Care
- Existing feeds will be supplemented to include more useful information as defined by ICS priorities and the Shared Record group. This will include pathology and medications
- Wider partners such as hospices, care homes and voluntary sector will be able to access information where appropriate and possible within the constraints of information governance

### Shared Record Group (care professional development of product)
- Working closely to provide information not currently available in the record in order to enable professionals to make better decisions at the point of care such as forward planning and daily life information
- Enabling resident information to be presented back to professionals within the shared care record
- Continual development of the platform based on professional user feedback
- To continue to work towards a longitudinal record, restructuring information to provide the most useful information to professionals in relevant form
- Delivering in a triple value concept by utilising capability delivered through the Intelligence platform in order that residents satisfaction can be captured as an outcome

### Connected Intelligence Platform
- Statutory organisations contributing information from their data warehouses into the Intelligence platform to support population health
- Linking data from multiple sources at patient, ward and postcode level
- Having a fully operational platform for use by professionals at an anonymised, pseudonomised and patient level. There will be robust IG and security controls in place to ensure appropriateness of access and use
- Incorporating and merging patient captured information with care professional information. This will include qualitative information as well as quantitative information

### Share Your Care (Personal Health Record - PHR)
- The platform will have active signposting, nudging capability and will empower residents to take greater ownership of their wellbeing
- Person Health Record (PHR) will be made available to residents across the ICS with capability including, viewing appointments, viewing care information and provide access to carers
- The PHR will be able to link with vetted apps, wearables and web based tools. This will allow residents to send information to care professionals and receive information as warranted as part of wider system transformation. The PHR solution will integrate with NHS App
7. Shared Care Record

How will services look by the end March 2020?

Population

• Care professionals will have access more complete information enabling residents to tell their story once
• Residents will be able to contribute to the shared record supporting person focussed outcomes
• Creating a longitudinal, linked dataset will enable services to be planned more holistically supporting better individualised care
• A platform will be available for residents that underpins core deliverables including opt out, aggregating appointments, allowing residents to contribute to their care record, with a strong emphasis on self-care and prevention
• An Intelligence platform that supports population health analytics

Workforce

• Gives care professionals access to more information allowing them to make more accurate decisions and increasing efficiency and releasing time to care
• Ability to record shared decisions and for those decisions to be viewable from across the system supporting new ways of working
• Enabling information to be presented in a longitudinal way, to be presented to professionals across the system in areas such as pathology
• Enabling new ways of working by providing information to both residents and care professionals to allow resources to be targeted in the most efficient way and to be more closely aligned to resident focussed outcomes
• Capability to better identify demand of services and workforce modelling

System

• Increases efficiency within the wider system. Potential to reduce duplication and variation across the system
• Increasing utilisation of the system by presenting significant amounts of information and presenting it in the most professionally logic view
• Enables planning, population health and wider determinants of health to be incorporated into care. Delivering in a triple value concept by integrating qualitative and quantitative information
• Targeted, personalised wellness programmes for residents which will support greater self-care via social prescribing. This will support patients to live better for longer
• Consolidated dashboards that support the identification of key issues or opportunities for the ICS. Tools that support consistent and best practice evaluation of programmes and interventions
7. Shared Care Record

**Outcomes and Benefits**

- Improved efficiency for health and social care staff by having access to information or having signposts to who holds the information
- Supports improved patient safety by providing critical patient information at the point of care
- Better decisions will be made at the point of care as a result of having access to a holistic and contemporaneous shared record
- Releasing time to care at the point of delivery by reducing the need for telephone calls to ascertain recent care history
- Improving the quality of shared information through:
  - Developing shared language across the system
  - Agreeing the key information streams which enhance onward decision making at a system level
  - Iterative improvement of the shared care record to keep pace with professional expectation
  - Providing guidance in terms of future plans which may be in place for our population

- Residents empowered to take greater ownership of their wellbeing supporting them to live better for longer

**Key Risks and Mitigation**

- There is a risk that other workstreams will not be able to transform current operational and clinical practice at pace and scale to inform digital enablement
- The technical implementation is complex and can lead to delays. Mitigating actions include bringing organisational and supplier teams together to work closely and flag exceptions as early as possible. It is important for it to be seen as a clinical transformation programme rather than a digital programme to ensure adoption continues
- The quality of information is dependent on the quality of information already in primary source systems. This is variable across organisations currently. This will be mitigated through our professional group setting standards and then collaborating with organisations in order to ensure that the information needed is recorded in a way that can feed into the shared care record
## 7. Shared Care Record

### Milestones

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<td></td>
</tr>
<tr>
<td>System</td>
<td>1m+</td>
<td>• Releasing time to care and improving experience for care professionals and residents</td>
<td>• Improved quality of shared information</td>
</tr>
<tr>
<td></td>
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<td>• Improved patient safety by providing critical patient information at the point of care</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Residents empowered to take greater ownership of their wellbeing supporting them to live better for longer</td>
<td>• Improved use of health and care resources across ICS and borders</td>
</tr>
</tbody>
</table>
# 7. Shared Care Record

## Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• First improvement request implemented on live system (Daily life wireframe)</td>
<td>• Alerts/Notifications- system agreement over which alerts to include from multiple providers</td>
<td>• First enhanced module (Daily Life) deployed</td>
<td>• Care Planning Module deployed with first cohort.</td>
</tr>
<tr>
<td>• Medications as designed by group go live</td>
<td>• Transformation activity completed to identify where information is best captured for Daily Life</td>
<td>• Care Planning Module into design phase with supplier</td>
<td>• Patient outcomes metric (triple value healthcare) delivered</td>
</tr>
<tr>
<td>• Buckinghamshire information incorporated into Connected Care</td>
<td>• Integration with Intelligence Platform live</td>
<td>• EPMA integration from Frimley and BHFT completed</td>
<td>• Alerts and notifications deployed</td>
</tr>
<tr>
<td>• NEH&amp;F information incorporated into Connected Care</td>
<td>• Scope defined for triple value healthcare measurement</td>
<td>• Move to cloud based Azure solution completed</td>
<td>• Enhanced social care information incorporated</td>
</tr>
<tr>
<td>• Frimley &amp; Wexham context launch live</td>
<td>• Application against cohort on maternity pathway tested</td>
<td>• Diagnostics, results and procedures from Frimley Health included</td>
<td>• Secondary care correspondence incorporated into Connected Care</td>
</tr>
<tr>
<td>• Context launch in Primary Care live across all practices</td>
<td>• Technical capability for system dashboard to feed from Connected Care tested</td>
<td>• Integration with appointment systems completed</td>
<td>• Integration with third party applications completed</td>
</tr>
<tr>
<td>• Pilot cohort of patients utilising patient health record</td>
<td>• First use case live and in clinical operational use (Immunisations and screening)</td>
<td>• Integration between Connected Care PHR &amp; NHS App pending national delivery</td>
<td>• Live with multiple cohorts of residents across the ICS</td>
</tr>
<tr>
<td>• SUS feed supplementing the live operational data in the platform for direct care</td>
<td></td>
<td>• Further use cases live supporting ICS priorities</td>
<td>• Align with LHCRE completed to support record sharing across borders e.g. Surrey</td>
</tr>
<tr>
<td>• Communication with public initiated for how information is being used by the ICS</td>
<td></td>
<td></td>
<td>• Integration completed cross-borders including Buckinghamshire to support with sharing of best practice</td>
</tr>
</tbody>
</table>

## Delivery Vehicle

- **Patient Portal**
- **Technical Deployment**
- **Shared Record Group**
- **Intelligence Platform**
Urgent and Emergency Care

Aim
The strategic vision for Urgent and Emergency Care across the Frimley ICS System is to provide an integrated ‘whole system’ approach which is patient and public centred, focused on improving clinical outcomes through service integration and support innovation across the system. This means that our patients do not see the joins between services and that information is available at every stage. This reduces the need to take patients details many times over and that barriers are removed when patients move between other services or professionals involved in their care.

Description
The programme aims to realise the ambition of the Frimley ICS Urgent and Emergency Care Delivery Plan in the context of supporting patients who access Urgent and Emergency Care for both physical and mental health. From a public perspective, there will only be four points of access to Urgent and Emergency Care services: via 111, Primary Care including alternative community services, 999 and A&E. Regardless of the point of access, there will be a consistent approach dependent on the level of need. In developing our ICS we will, through the transformation of Urgent and Emergency Care, develop vertical integrated care through GP, Secondary, Community and Social Care provision and horizontal integration through the use of flexible workforce and enabling IT systems. This programme of work is highly dependant on deliverables in our communications, digital and IT workstreams, together with the workforce development and capital build Programmes at Wexham Park, Heatherwood and in Primary Care which will become the enablers to true long term innovation. For example, a new Emergency and Assessment Centre will be opened at Wexham Park in Spring 2019.

Given the complex nature of patient flows across different services, Urgent and Emergency Care services cannot function in isolation and the process requires a whole system and multidisciplinary collaborative approach across Acute, Primary and Community-based services and Social Care. To deliver this level of transformation the 7 Pillar delivery approach adopted previously has been updated locally and now comprises of 111 including DOS, Clinical Assessment Service, On the Day urgent care (including UTCs or alternatives), Ambulance, Hospitals and Hospital to Home. Each Pillar continues to have a set of deliverables. Whilst the vision and strategy runs across the ICS, the timescales for delivery will be variable across the North and South and the detail behind the Pillar Plans reflects this. The oversight of the plans and delivery sits with the Frimley ICS Urgent and Emergency Care Delivery Board, and each of the Pillars (with the exception of GP Access and UTC) reports directly to that Board. During the course of the year improved pathways will be introduced and service improvements made including the following:

- Hampshire and Surrey Heath CCGs 111 Integrated Urgent Care (IUC) and co-design
- East Berkshire CCG On the Day Urgent Care Programme which includes Out of Hours (OOHs), Urgent Treatment Centres and extended access
- North-East Hampshire and Farnham CCG Community Services

We have confidence that these will help us to deliver a locally responsive and coherent Urgent and Emergency Care System that responds to both local imperatives and national expectations that together will provide an improved, seamless and responsive care system for those in our population who need it.
Urgent and Emergency Care

Deliverables

To ensure delivery of the National Performance Standards (subject of in year confirmation of new standards) and the High Impact Changes for managing transfers of care through the following which are detailed in the Urgent and Emergency Care Delivery Plan:

- **111 & Directory of Services Development (DOS)** – Telephone and On Line facilities in place, that enables self care, clinical advice, call back and direct booking into appropriate services. Updated accurate DOS Selections to support alternatives to A&E and all commissioned services
- **Clinical Assessment Service** – Development of the clinical assessment service that will support 999/111, interfaces with OOH services, community services, social care, acute and mental health services
- **On the day Urgent Care** – Development of a number of pathways and services which include but not limited to; extended access in primary care and network children and Young People urgent care, new national standards for Out of Hours (OOH) Primary Care as part of an Integrated Urgent Care service, Urgent Treatment Centres (UTCs, previously Minor Injury Units and Walk In Centres) as alternatives to A&E and support unnecessary attendances, including High Intensity User. East Berkshire CCG will design a new model of urgent care as part of their ‘On the Day Urgent Care Programme’ during 2019-20
- **Ambulance Services** – The ambulance service will offer a more equitable and clinically focussed response that meets patients’ needs with access to patient information, services information and electronic prescribing at scene. Handovers between ambulances and hospital A&E Departments should not exceed 30 minutes
- **Hospitals** – Patients will get specialist assessments at the start of their care for their physical and / or mental needs and those patients who could be better treated elsewhere will be streamlined to those settings. This will include the further development of the following: Frailty Pathways; Same day emergency care and improved effective handover (particularly at night and weekends). Our focus will be specifically on reducing inappropriate length of stay for inpatients, including ongoing and sustained attention on Long Stay Patients who have been in hospital for over 7 days. We will continue to rollout seven-day services to the appropriate specialist services. This will be supported by a new Emergency Department (ED)/Assessment Centre at Wexham Park Hospital achieving transformation of the model of care
- **Hospital to Home** – We will improve the assessment process and ensure that patients are able to return ‘home’ as soon as possible 7 days a week. If home is not the best place for their immediate care, they will be transferred promptly to the most appropriate setting for their needs. Focus on maximising assessment outside of the hospital setting and ensuring that Delayed Transfers of Care (DTOC) are minimised and are maintained below the Localised and National targets. Utilising the use of technology to eliminate Handover Delays and optimising the time taken for patients assessments and onward care

There are also a number of key deliverables within other ICS programmes:

- **GP Access including Network development** – 7 day access joint work across the system to reduce ED attendances/admissions and delayed discharges
- **Mental Health Crises Response** – 24/7 access to crises resolution and home treatment teams and coverage of liaison of mental health teams
- **Integrated Care Decision Making** – 7 day access to community teams and urgent response to those in need to prevent admission
Urgent and Emergency Care

How will services look by the end March 2020?

Patients will have an improved experience of Urgent and Emergency Care services, this will be achieved by all NHS and Social Care Providers having access to their medical records, this will enable any relevant medical condition and treatment be taken in account by those giving Urgent Care. It will also improve liaison between Providers so that patients will not have to repeat their stories or medical history to numerous health and care professionals and also enabling a more speedier response when discharging patients from hospital.

Patients will have an improved response to their Urgent care needs; this will be achieved by having better access to on the day primary care appointments seven days of the week. When primary care is closed or patients need advice, the 111 service can be accessed by telephone and online, their needs will be assessed and if required, they will be able to speak to a clinician both for physical and mental health requirements as part of the triage process and if needed will be able to be booked into an appointment in primary, community or acute services.

Patients who call 999, will go through a similar triage process to 111 services provided and will receive an appropriate response to meet their needs in the case where an ambulance crew or alternative provider needs to be dispatched to carry out this response will be based on the patients clinical needs either to a life threatening event or other requirements i.e. falls etc. Where possible patients will be treated at the “scene” and only transferred to hospital if their needs require this.

Patients’ experience of acute hospital treatment will be streamlined appropriately to their needs. Frimley Health will stream patients dependant upon the severity of their patients needs including provision of an acute frailty service with the majority of people receiving Same Day Emergency Care (SDEC).

Where patients need a longer stay in hospital, they will be discharged as soon as they are medically stable back to their own home with support from Health or Social Care or into a mixture of Community Hospitals, Care/ Nursing Homes. Delays in the discharge process will only happen on an exceptional basis.

The NHS App will be available for patients to access 111, GP records and book appointments.

Staff will experience an improved working environment in a number of areas and increase the amount of work that is carried out collaboratively across organisational boundaries to deliver Integrated Care Pathways. They will also work with improved information systems to manage capacity and on the day demand including the implementation the emergency care data set.

Health and Care Professionals will have on line access both inside the Hospital /Community setting or remotely in the patients’ homes.

Following the results of the national clinical standards review staff will start to test and begin implementing the new emergency and urgent care standards.
Urgent and Emergency Care

Outcomes and Benefits

- Sustained delivery and improvement in the 4 hour A&E target
- Effective clinical streaming in Emergency Department (ED) to be undertaken within 15 minutes of arrival
- Sustain and continue to improve patient flow inside the hospital to delivery a reduced bed occupancy of 92%
- Sustain the December 2018 target of 26% and continued a reduction in the number of long stays patients and long stay beds from the March 2018 baseline by March 2020. All patients will have a EDD within 48 hour of admission
- Continue to make process on reducing delayed transfers of care (DTOC) position (local targets to be set through the Better Care Fund plans)
- Less than 15% of Continuing Health Care assessment take place in a hospital setting
- 100% of Health and Wellbeing Boards (HWBs) to be at the mature or exemplary level within the HIC maturity model by 31 March 2019
- Ensure that 100% of ambulance handover occur within 30 minutes
- Delivery of integrated urgent care through an enhanced NHS 111 service with 50% of calls receiving a clinical assessment
- Increase the percentage of people triaged by NHS 111 that are booked into a face to face appointment, where this is needed, to greater than 40% by 31 March 2020
- Delivery of the Ambulance Response Programme targets for category 1,2,3,4 calls
- Delivery of a safe reduction in the number of ambulance conveyances to ED
- Increase the utilisation of the NHS app to access digital services
- 24/7 Access to Crisis Resolution Home Treatment Teams and liaison teams for adults and children

Key Risks and Mitigation

- Workforce capacity, recruitment and retention in health and social care. This risk will be mitigated through the workforce strategy
- Capacity to manage a number of change programmes across the system. This risk will be mitigated through development of plans and delivery through the A&E Delivery Board
- Delivery of enabling work programmes to support change i.e. IT and Estates. This risk will be mitigated through the work programmes
- Increased patient demand for physical and mental health services. This will be mitigated through self care, increased access to primary care, integrated urgent care services and utilisation of technology such as E –consult and on line services
- Non-elective admissions cannot be reduced in line with forecast plans. This risk will be mitigated by hospital pillar plans to reduce LOS and reduction in to DTOC alongside a higher focus on discharge to assess, rehabilitation using resources and skills across all partners more effectively
- Lack of political and stakeholder support to proposed service change. This risk will be mitigated by patient and public involvement
- Capacity to manage a number of procurements across systems including community services, integrated urgent care and OOH urgent care programme, this will be mitigated by project and resource planning to support these programmes of work
- Impact of new ED opening at Wexham Park Hospital site mitigated through planned implementation and pathways
- Impact of changes to the payment mechanisms including changes to CQUIN for 2019-20 mitigated by planning and review
# Urgent and Emergency Care

## Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| Network | ~50k      | • Patients will have effective and easier access to urgent care services in the community, including those in crisis  
          |                                                    | • Improved experience for people and their families  
          |                                                    | • Improved patient satisfaction with urgent care services  | • Reduced waiting times in A&E  
          |                                                    |                                                                             | • Reduced number of ambulance conveyances to ED  
          |                                                    |                                                                             | • Reduce A&E attendances  
          |                                                    |                                                                             | • Reduced number of patients who become a DTOC  
          |                                                    |                                                                             | • Increased in direct booking into OOH, GP or alternative community services |
| Place   | ~250-550k | • Improved access to on the day services resulting in improved patient experience          | • Reduced waiting times in A&E  
          |                                                    |                                                                             | • Reduced ambulance handover delays at hospitals  
          |                                                    |                                                                             | • Reduced number of ambulance conveyances to ED  
          |                                                    |                                                                             | • Reduced number of patients who become a DTOC  
          |                                                    |                                                                             | • 85% of Continuing Health Care assessment take place out of hospital |
| System  | 1m+       | •                                                                    | • Improved flow within the system  
          |                                                    |                                                                             | • Improved staff retention and workforce satisfaction  
          |                                                    |                                                                             | • ICS system to be amongst the best performing UEC system in England  |
## Urgent and Emergency Care

### Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trajectory agreed with Frimley Health to reduce length of stay for patients who have been in hospital or over 7 days and over 21 days respectively</td>
<td>• Q2 Reduced Length of Stay trajectory at Frimley Health delivered</td>
<td>• Q3 Reduced Length of Stay trajectory at Frimley Health delivered</td>
<td>• Q4 Reduced Length of Stay trajectory at Frimley Health delivered</td>
</tr>
<tr>
<td>• Task and finish group established to review reasons for ambulance conveyance to ED, local pathway and alternatives that could be used to agree a plan to deliver a safe reduction in ambulance conveyance to ED</td>
<td>• Delivery plan signed off for a safe reduction in ambulance conveyance to ED. Plan commenced</td>
<td>• Q3 plan for a safe reduction in ambulance conveyance to ED delivered</td>
<td>• Q4 plan for a safe reduction in ambulance conveyance to ED delivered</td>
</tr>
<tr>
<td>• March baseline for Same Day Emergency Care (SDEC) activity in accordance Emergency Care dataset requirement agreed</td>
<td>• Deliver DTOC Trajectory for Q2 SDEC in place by Sept 2019</td>
<td>• Q3 plan for SDEC non elective admissions delivered</td>
<td>• Q4 plan for SDEC non elective admissions delivered</td>
</tr>
<tr>
<td>• Specific pathways agreed that will be developed to increase SDEC activity during 2019-20 with Frimley Health</td>
<td>• Development of agreed SDEC pathways commenced. Local trajectory to deliver at least the 30% SDEC national standard of non elective admissions agreed</td>
<td>• Q3 SDEC Frailty service in place by end Dec 2019</td>
<td>• Q4 plan for SDEC non elective admissions delivered</td>
</tr>
<tr>
<td>• Local trajectory agreed for NHS 111 direct booking into OOH, Alternative Community Services and GP services</td>
<td>• Q2 trajectory for NHS 111 direct booking for OOH, Alternative Community Services and GP services achieved</td>
<td>• Q3 trajectory for NHS 111 direct booking into OOH, Alternative Community Services and GP services achieved</td>
<td>• Q4 trajectory for NHS 111 direct booking into OOH, Alternative Community Services and GP services achieved</td>
</tr>
<tr>
<td>• On the Day Urgent Care Programme. Options shortlisting completed. Public consultation commenced if required</td>
<td>• On the Day Urgent Care Programme decision made on future model</td>
<td>• On the Day Urgent Care: In light of decision made in Q2 implementation of plans or alternative arrangements commenced</td>
<td>• On the Day Urgent Care: Next steps on decision made in Q2 on future service model initiated</td>
</tr>
<tr>
<td>• Winter Planning &amp; Review - Review of winter 2018-19 completed. Recommendations made for 2019-20 to A&amp;E Delivery Board</td>
<td>• Winter Planning &amp; Review - Winter planning commenced. Outline plan produced by 30.9.19</td>
<td>• Designation of all our existing WIC, MIUs, UCCs etc. confirmed by end Dec 2019</td>
<td>• Winter Planning &amp; Review - Complete winter plan and initiated</td>
</tr>
</tbody>
</table>

### Winter Planning & Review

- Review of winter 2018-19 completed.
- Recommendations made for 2019-20 to A&E Delivery Board
- Designation of all our existing WIC, MIUs, UCCs etc. confirmed by end Dec 2019
**Aim**

Frimley Health and Care places a strong focus on supporting good mental and physical health for its population and we will support the delivery of the NHS Five Year Forward View for Mental Health (FYFVMH) and the NHS Long Term Plan. We will deliver effective and compassionate care which connects people’s mind, body and social context to enable them to live the best life possible. Our ambition is to work within local communities to facilitate straightforward access to care and support as early as possible and to offer people more choice about the services they receive. We want people to have a good experience of transitioning between services and have continuity of care between children and adult mental health/learning disabilities services as well as between primary and secondary care. We will ensure that the work we do as a system adds value to the local initiatives and reduces health inequalities for vulnerable people.

**Description**

Frimley Health and Care established a Mental Health and Learning Disabilities (MH and LD) Programme during 2017-18 to deliver the outcomes for the NHS Five Year Forward View for Mental Health (FYFVMH) and to add value at system level. In the main, the outcomes of the FYFVMH will be delivered locally, with the MH Programme having oversight and providing assurance for these outcomes. The system wide MH programme will also support the delivery of services to people with learning disabilities and autism where there is a co-occurring mental health need. Our aim is to work alongside the ICS Transforming Care Programmes to support the development of community services, improve access to physical healthcare and reduce inappropriate inpatient admissions for people with LD and/or Autism.

**Priority 1: Developing a Joint Strategic Plan**

We will continue to work collaboratively to learn from one another whilst ensuring a local approach. The CCGs will continue to meet the Mental Health Investment Standard as a minimum. In 2019-20 we want to further improve the relationships by working together to develop a joint strategic planning, delivery and assurance initiative as a system of providers and commissioners. Part of this initiative will include an ICS investment strategy to ensure transformation of mental health services and parity with other parts of the health and care system. We also recognise the challenges we face regarding our mental health workforce over the coming years and we believe that together as a system we can address this challenge and we want to develop a workforce plan to ensure we are able to deliver sustainable mental health services across our system for years to come.

The Mental Health Programme has identified a number of clinical priorities for 2019-20 where working as an ICS will realise the best outcomes as outlined below.
**Description**

**Priority 2: Children and Young People access to mental health services**

We recognise the national pressures on ensuring our children and young people under 25 receive high quality support and care for their mental health and we want to work with other workstreams to ensure CYP’s access to mental health increases and that we are able to offer the care and support they need. Both our mental health NHS Trusts will be working together this year to look at this. In terms of supporting the delivery of mental health support teams in schools and colleges, during 2019-20 we will look to take the learning from the Wave 1 sites before undertaking work in this area in future years.

**Priority 3: Out of Area Placements (OAPs)**

This is a continuation of last year’s work, in which we set a system trajectory to reduce OAPs. OAPs has a significant impact on the experience and quality of care for people and their families. A system approach has enabled a strategy and action plan which we will now focus on delivering locally.

**Priority 4: Improving the treatment and experience for people with personality disorders**

As part of our work in 2018-19 with OAPs and Crisis we have recognised that as a system we are not offering the best possible outcomes for people with personality disorders across primary, acute and secondary mental health care. We want to improve this over the next year and will identify possible solutions that could be developed at neighbourhood and system level for this group of people.

**Priority 5: Development of primary care mental health and wellbeing support**

We recognise that most people are seen in primary care (at their GP’s) for their mental health concerns and that traditionally mental health services have not worked well in this setting and that GPs feel more support is warranted. We want to address this by ensuring that people get appropriate care and support for their mental health needs when they visit their GP. We also want to make sure that people with MH needs have good physical health and that regular health checks are in place for those with SMIs (as described in the FYFVMH). We will build on existing local initiatives to improve the integration of mental health in primary care and to provide evidence-based interventions at the earliest possible point. The Mental Health and GP Transformation workstreams are working together to set out a vision for a new service model across the ICS and will develop a business case for transformation funding within Q1 of 2019-20. As part of this work we have already received funding to jointly develop a workforce strategy for GP and MH Transformation.
Mental Health and Learning Disabilities

Description

Priority 6: Ensure we have easily accessible support and to commission 24/7 urgent, emergency and liaison mental health services

Our new priority of primary care will provide earlier support for people locally and it is anticipated that this will reduce the need for crisis pathways in the future. Last year our focus was on understanding local crisis services which improved access to mental health support 24 hours a day, 7 days a week for both children and adults. Crisis pathways cover Crisis Response and Home Treatment Teams (CRHTT), Core 24 mental health liaison teams embedded in accident and emergency departments, street triage teams working with the police to prevent people being detained, inpatient admissions, Children and Adolescent Mental Health Services (CAMHS), peer support, safe havens and crisis cafes. In 2019-20, we want to work towards reducing the variation in both access and outcomes for people experiencing a mental health crisis by developing a best practice framework. This will set good foundations for future work to enable us to add value at scale and consider how best to integrate the existing MH Single Points of Access for SABP/BHFT into NHS 111 – recognising that this is potentially complex given the local geography within the ICS.

Local Priorities – areas we will deliver at neighbourhood and place based level

The MH Programme plays a key role in sharing knowledge and learning, whilst also engaging people and receiving feedback from service users, carers and their families about their experience. We will develop meaningful outcomes that we can work together to achieve as well as ensuring the financial sustainability of MH Services. This involves linking closely with Transforming Care Programme Boards, Crisis Care Concordats and Suicide Prevention initiatives within the ICS.

Locally, many of the FYFVMH outcomes such as IAPT access and recovery, Individual Placement Services, perinatal services, physical health checks for people with severe mental illness are being delivered. The system is working to have oversight and report progress on these to NHS England and this will be further improved by our first priority to develop a joint strategic initiative. As a system we are working together to improve the quality of data submitted to the mental health services data set. A consequence of our relationships and regular meetings allows us to identify opportunities where bringing together all parts of the system can add value to our local work.
Mental Health and Learning Disabilities

How will services look by the end of March 2020?
People who use secondary care mental health services will continue to receive safe and good quality health and care services. They should receive this care in the right place at the right time and when they need support for their physical health they can access this with ease. If people are admitted to inpatient care they will be less likely to have to go out of area for their care and will therefore remain closer to family, friends and neighbours. We want to ensure that people who access mental health services in a crisis will receive a high quality and timely service and that when they feel in crisis they are able to access support rather than waiting for professionals to refer them for additional support.

People in primary care who need support for their mental health should be able to access this quickly and with reduced waiting times. In this year we want to develop a new service model and ask people their views on what this will look like.

Key Risks and Mitigation
- Demand increases for all services. This risk will be mitigated by mental health providers engaging with voluntary sector to support people and develop transformation plans for front door/single point of entry.
- Not having the right workforce in place – develop a workforce strategy to develop new roles and training
- Lack of funding. This risk will be mitigated through funding alternatives for hospital admissions upfront to shift the spend away from bed days (pump priming). We will work alongside local authorities to explore opportunities within 117 funding.
- Long term sustainability of funding received via bids – Steering Group to have sight of these plans across ICS
- Lack of system investment in MH integration and transformation

Deliverables
- Ensure OAPs consistently are under 199 overall bed days by April 2020 (56% reduction from April 2019) across our system
- Agree a framework of outcomes for people accessing crisis services across Frimley ICS
- Agree a pathway of care for people with a personality disorder across the Frimley ICS
- Commission a business case for additional funding to develop primary care mental health services across our system
- Set up a joint strategic planning, delivery and assurance initiative in the ICS
- Develop and agree across the ICS a mental health investment strategy
- Continue the mental health workforce plan, building on the work already completed and the Local Workforce Action Board (LWAB) funding with the GP Transformation workstream across the system
- Continue to meet the outcomes and standards for the FVFVMH locally – physical health checks for people with SMI and the dementia diagnosis rate will be delivered and monitored via place based systems, perinatal services, early intervention services, IPS, crisis response and home treatment and CORE 24 services through neighbourhoods. IAPT services will work both in neighbourhoods with GPs and on a larger place based level

Outcomes and Benefits
- Reduction in people being sent out of area for inpatient care
- Care being delivered closer to home when inpatient care is needed
- More choice in community mental health service provision
- Effective and easier access to services at all times for patients
- More choice in what support is offered 24/7 and where
- Improved health and wellbeing of patients
- Improved experience for people and their families
- Reduce waiting times in A&E and acute hospitals when psychiatric assessment is required
- Deliver 32% increase in access to CAMHS
# Mental Health and Learning Disabilities

## Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| Neighbourhood    | ~50k      | • Improved access to services at all times for people of all ages, including those in crisis  
• Improved experience for people and their families | • Reduction in people being placed out of area for inpatient care        |
| Place            | ~250-550k | • Increased choice for patients in community mental health service provision  
• Improved access to CAMHS  
• More choice in what support is offered 24/7 and where  
• Improved health and wellbeing of people of all ages | • Reduction in people being sent out of area for inpatient care  
• Reduce waiting times in A&E and acute hospitals when an psychiatric assessment is required |
| System           | 1m+       |                                                                           | • Reduction in people being sent out of area for inpatient care  
• Reduced variation in care of people with Personality Disorder (PD)  
• Improved integration of physical and mental health  
• Improved Access to Psychological Therapies (IAPT) |
## Mental Health and Learning Disabilities

### Milestones

<table>
<thead>
<tr>
<th>Priority 1: Set up a joint strategic planning, delivery and assurance initiative within the ICS</th>
<th>Priority 2: Children and Young People’s access to Mental Health services</th>
<th>Priority 3: Reducing inappropriate Out of Area Placements (OAPs)</th>
<th>Priority 4: Pathway of care for people with a personality disorder (PD) agreed across the Frimley ICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Principles established for a joint strategic planning, delivery and assurance approach to be delivered via the MH Steering Group, bringing together commissioners and provider organisations</td>
<td>• Deliver 32% increase in access to CAMHS</td>
<td>• Reduction of inappropriate OAP bed days across the ICS from 351 to 314</td>
<td>• Review completed of best practice available relating to care and treatment of PD</td>
</tr>
<tr>
<td>• Financial analysis undertaken to establish the level of MH spend across the ICS and the actual cost of individual pathways for MH services</td>
<td>• Map flows and identify areas for improved efficiency</td>
<td>• Q1 Data evaluation report completed to assess how often someone is discharged back to same placement after an admission</td>
<td>• Gap analysis completed including review of current Care Pathways and wider determinants of mental health (e.g. housing and accommodation) to consider people with PD at place and system level</td>
</tr>
<tr>
<td>• Investment strategy developed, informed by the FYFVMH and NHS Long Term Plan</td>
<td>• With the CYP programme, co-develop a CAMHS access and improvement strategy based on the results of the mapping exercises</td>
<td>• Service improvement options paper finalised including reference to the evidence base and cost efficient commissioning</td>
<td>• Future design of pathways/services proposed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduction of inappropriate OAP bed days across the ICS from 314 to 273</td>
<td>• Business case completed to secure investment</td>
</tr>
<tr>
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<td>• Service Improvement Delivery Plan completed</td>
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</tbody>
</table>
# Mental Health and Learning Disabilities

## Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
</table>
| **Priority 5: Development of primary care mental health and wellbeing support**  
- Business case completed for additional funding to develop primary care mental health services across our system. Including review of existing local initiatives and workforce capacity and capability across Primary and Mental Health Care (in line with workforce expansion targets)  | **Mobilisation of Place-Based Wellbeing Service in East Berkshire**  
- Business Case submitted to Programme Delivery Board for approval to test new primary care model in NEHF/Surrey Heath | **New model of primary MH service mobilised in NEHF/Surrey Heath**  | **Six months post-implementation review of the Place-Based Wellbeing Service in East Berkshire completed**  
- Recommendations developed for system wide scaling of primary care MH model(s) |

| **Priority 6: Improving access to crisis services for people of all ages**  
- Task and Finish Group established to develop ICS Framework for improving access to crisis MH Services. Identifying where value can be added and where partnership working can be enhanced.  
- Gap analysis report produced to identify gaps in existing provision | **Peer review visits undertaken including best practice for care planning and crisis planning**  
- ICS Framework proposals developed  
- Interdependencies with other workstreams identified. | **ICS Framework proposals implemented**  
- Monitoring process established | **ICS Framework proposals implemented**  
- Monitoring process established |

| **Workforce**  
- ICS workforce planning lead recruited and in post | **Financial analysis undertaken to establish the level of MH spend across the ICS and the actual cost of individual pathways for MH services**  
- Review of workforce plans completed | **Investment strategy developed (including workforce plans), informed by the FYFVMH and NHS Long Term Plan** | |
**Aim**

Our vision is for maternity services to become even safer, kinder, more personalised and family-friendly. We have identified the key areas of ‘safety’, ‘choice and personalisation’, ‘digital’, ‘workforce’ and ‘pre-conception and maternal health’.

**Description**

‘Better Births’ published by NHS England in 2016 outlined the national vision for maternity services moving towards 2020-21 focusing primarily on improving safety, choice and personalisation for women and their families. Our ‘Local Maternity System (LMS)’ which is co-terminus with the Frimley Health and Care ICS footprint, brings together key stakeholders to steer the transformational change programme and will continue to meet quarterly through 2019-20.

In 2019-20 we plan to focus on our workforce aligning with the NHSE 10 year Long Term plan and understanding how national initiatives will impact on our system. We will prioritise local action to address our workforce challenges. Our organisational development and leadership programme will continue into 2019-20 and we are keen to enable delegates to influence the transformation programme. Our preconception work aligns with the NHSE 10 year Long Term plan focus on Healthy Childhood and Maternal Health Life Course. Preconception and Maternal health remains a high priority. As we start to implement other elements of the programme we will release capacity to focus on this. We are keen to address inequalities across our system by targeting support to those with the poorest outcomes.

We are committed to co-production and our Maternity Voices Partnership (MVP) continues to develop and grow with a rolling programme of engagement and feedback activities. Our MVP have launched a survey to understand women’s views and how they would like to shape services going forward, the results of which will be embedded in what we do in 2019-20. We are planning to hold a series of focus groups with Healthwatch organisations from our five local authorities to ensure that women from seldom heard backgrounds are listened to.

We will focus on harnessing technology to improve women and workforce experience. We will utilise videoconferencing facilities to promote cross site working and embed the use of an app for women with gestational diabetes. Maternity is one of the clinical areas prioritised within the Local Health Care Record Exemplar programme and we will work toward better interoperability between the two main hospitals sites, and also into the community setting. We will work towards submitting data for Maternity Services Data Set 2 and utilise this information and the maternity digital maturity assessment to develop our plan.

We will deliver our continuity of care programme expanding the offer to vulnerable women and achieving 35% by March 2020 and over 50% by 2021, embed our personalised care plan and pilot community maternity hubs. Perinatal mental health services will be available to all women across our system and we will facilitate conversations across providers.
Maternity

Description
Through 2019-20 we will start to focus on utilising technology and digital solutions to support our work in parallel with delivering and embedding existing initiatives.

Digital
We will establish a digital work stream to identify ways to support our programme. We will explore options for patient held personalised records and for providing women access to manage their own appointments working closely with our ‘Connected Care’ work stream and ICS digital leads. We will use on line forums to empower women to have healthier pregnancies and safer births. We will develop our Maternity Offer so that women have good information on which to base their choices.

Preconception and Maternal Health
In response to a Maternity Voices Partnership survey we would like to utilise online platforms and social movement to improve education and knowledge of pre-conception and maternal health, promote healthy cooking and eating, breast feeding and smoking cessation. We would like to focus on promoting peer support for new mums and future mums. We are planning to undertake the Challenge Leadership Results (CLEAR) smoking cessation tool ensuring all women are offered specialist support to help them quit. We will review the feasibility of the diabetes pre-conception clinic. We know that Health Visitors are key and we will engage with them and wider stakeholders. We will continue to work with all of our specialist perinatal mental health providers to ensure equity of service provision. We will link with the ICS Make Every Contact Count (MECC) team and Prevention programme, our Mental Health programmes and child health teams aiming towards on going healthy lifestyles for women and their families. We will continue to improve our Baby Friendly ratings.

Workforce
Our organisational development and leadership programme will create a group of change agents that will be able to shape and deliver transformational change across the system. We will continue to work with our multi-professional workforce group and Health Education England to understand the impact of national initiatives locally, understand the impact of our continuity of carer and community hub plans on our workforce, and prioritise initiatives to address remaining workforce issues.

Safety
We will continue to share incidents with neighbouring LMS’s through the shared governance group, report to NHS Resolution for babies that meet the Each Baby Counts criteria, and utilise the perinatal mortality tool. We will review and embed the learning from our perinatal mortality review. We will ensure that safety initiatives aligning to Better Births are captured including those outlined within the Maternity Incentive Scheme and Saving Babies Lives within our system governance reporting frameworks. Our Safety Collaborative project will be embedded ensuring women that need to be seen urgently in clinic do not have to wait.

Choice and Personalisation and Community Care
We will implement our new personal care plan which has been co-produced with our Maternity Voices Partnership. We will ensure that this is accessible for women who do not use English as their first language. We will survey women and further engage with women from seldom heard backgrounds to understand the impact of the plan and assess whether women feel their care planning is truly personalised. We will refine our plans for increasing maternity led births. We will embed the Continuity of Carer diabetes pathway and identify further opportunities to achieve Continuity of Carer. We will pilot Community Maternity Hubs in the north and south of the system. We will assess and review the pilot and if successful plan to roll out hubs to the rest of the system aligning with the Integrated Care Decision Making programme and the establishment of GP Networks.
Maternity

How will services look by the end March 2020?

• Women will feel supported in making choices that are right for them have healthier pregnancies and births. Women will feel that their care is personalised and flexible including when and where they receive antenatal and post natal care with the option of being seen in a hub at a time outside of normal working hours.

• Women will feel supported through the use of social media and have access to peer support and education including breast feeding and healthy eating and exercise.

• Women will feel empowered to use technology to improve their health and to manage their healthcare and feel able to shape future services and care through membership and engagement with our local Maternity Voices Partnership.

• Our workforce will feel supported and enabled to develop and to shape future services, through opportunities such as our local leadership and organisational development programme.

• Midwives will feel supported through working with colleagues in hubs and will be able to network and integrate with co-located services and will feel that they are spending less time travelling across the system.

• Labour ward midwives will feel empowered in caring for diabetic women as they will be part of a ‘diabetes team’ and will have had additional support.

Outcomes and Benefits

• Improved health status of women and babies.
• Improved satisfaction of women with their maternity services.
• Improved levels of motivation in maternity workforce.
• Increased levels of workforce feeling supported.
• Fewer women will lose their baby.
• For women receiving Continuity of Carer, fewer will experience pre-term birth or have an episiotomy.
• Women will have informed choice of care.

Deliverables

During 2019-20 we will deliver the following within this work stream:

• Women booked on to Continuity of Carer pathway - System Level
• A Personalised Care Plan rolled out and available digitally to women - System Level
• Proposals for change presented to the LMS Board by delegates attending the leadership programme - System Level
• Maternity Offer published and available to women - System Level
• Completed CLEAR tool review - System Level
• Pilot Hubs established - Place Level
• Run a bespoke OD/leadership programme to support maternity transformation – System Level

Key Risks and Mitigation

• Risk: Lack of digital interoperability with the challenge of having two patient administration systems across the Trust. This risk will be mitigated by continuing to link with Connected Care work streams and the Local Health and Care Record development.

• Risk: Workforce risk with continued challenge of vacancies. This risk will be mitigated through work with our workforce group to understand local challenges and prioritise solutions.

• Risk: Complexity of different working on different sites. This risk will be mitigated by continuing to work at a system-wide level, identifying inequalities and addressing them.

• Risk: Different approaches from different local authorities to healthy lifestyle support. This risk will be mitigated by continuing to work at a system-wide level, identifying inequalities and addressing them.
## Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood</td>
<td>~50k</td>
<td>• Improved satisfaction of women with their maternity services</td>
<td>• Optimised Workflow in general practice (tbc)</td>
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<tr>
<td></td>
<td></td>
<td>• Improved levels of motivation in maternity workforce</td>
<td>• Released space in GP practices</td>
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<td></td>
<td></td>
<td>• Increased levels of workforce feeling supported</td>
<td>• Improved levels of motivation in maternity workforce</td>
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<tr>
<td>System</td>
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<td></td>
<td></td>
<td>• Improved women’s experience</td>
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<td></td>
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<td>• Improved satisfaction of women with their maternity services</td>
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## Maternity

### Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>• Diabetes model of continuity of carer initiated</td>
<td>• Digital plan agreed incorporating system wide interoperability</td>
<td>• Maternity Offer website created enabling women to make informed decisions personalising their care</td>
<td>• Patient Held Record available to women and pulling data from relevant apps</td>
</tr>
<tr>
<td>• Fleet and Maidenhead Hubs established</td>
<td>• Maternity organisational development/leadership programme delivered. Plans for implementing proposals developed</td>
<td>• Online forums and peer support established and utilised to improve pre-conception and maternal health-this will include healthy eating and breast feeding</td>
<td>• 19% of women giving birth in midwifery lead settings</td>
</tr>
<tr>
<td>• Gestational diabetes app implemented across the system</td>
<td>• Logic model developed incorporating all maternity initiatives</td>
<td>• Engagement with seldom heard groups undertaken supported by the five Healthwatch organisations</td>
<td>• 95% of women will have received a care plan</td>
</tr>
<tr>
<td>• Future models for Continuity of Carer and plan for implementation agreed</td>
<td>• Prevention plan and framework agreed</td>
<td>• Financial and work force modelling undertaken to understand overall impact on maternity services</td>
<td>• 35% of women booked onto Continuity of Carer pathways</td>
</tr>
<tr>
<td>• 20% women receiving continuity of carer - Diabetes and Hubs</td>
<td>• Make Every Contact Count training rolled out across key workforce</td>
<td>• Key recommendations from Avoiding Term Admissions to Neonatal Units (ATAIN) implemented</td>
<td>• Still birth and neonatal death crude rate reduced to 4 per 1000 births</td>
</tr>
<tr>
<td>• Cross site teleconferencing available to workforce supporting alignment of safety meetings</td>
<td>• Motivational interviewing delivered to appropriate workforce</td>
<td>• Evaluation of hub pilots completed</td>
<td>• Compliance achieved with data input for Maternity Services Data Set 2. Outputs of data set reviewed</td>
</tr>
<tr>
<td>• National Maternity and Neonatal Collaborative safety project completed and 80% of women triaged as urgent seen within 20 minutes at Maternity Assessment Centre</td>
<td>• Clear Tool undertaken and learning actions agreed</td>
<td>• Hub roll out initiated (dependent upon evaluation findings)</td>
<td>• Diabetes Continuity of Carer pathway reviewed and next steps agreed</td>
</tr>
<tr>
<td>• Care plan issued to all women – available in 6 languages</td>
<td>• Compliance with updated Saving Babies Lives confirmed</td>
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<td>• Further models of Continuity of Carer implemented</td>
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<tr>
<td>• Workforce workshop completed</td>
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<tr>
<td>• Perinatal mental health ongoing plan agreed</td>
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Aim
The aim of this programme is to establish a system wide approach that will focus on those issues where working at scale and over a Frimley ICS footprint adds measurable value in terms of improved health outcomes for children and young people. We have now agreed that the focus for 2019-20 is to develop a work plan which will inform a longer term programme of work which responds to the requirements of the NHS Long Term Plan.

Description
Frimley Health and Care places a strong focus on supporting the overarching good mental and physical health and well being of children and young people (CYP). We are committed to ensuring that all elements of a child’s health needs are considered and to ensure that we view mental health on a par with physical health. During 2019-20 we will embed a programme of improvement which will deliver our system aspiration, recognising the importance of a cohesive and collaborative focus on improving outcomes for the children and young people living in our area. The key priority areas will include: Neurodiversity support, Crisis and urgent care, and the promotion of well being and personal responsibility.

The programme will collaborate with the ICS Mental Health (MH) Programme in support of the delivery of the improvements in secondary mental health and learning disability care and achievement of the required standards.

The work programme will have direct relationships with other key ICS programmes such as Prevention and Self Care (P&SC), Maternity and Mental Health and Learning Disabilities, with shared membership sub-groups where appropriate. It is intended that the work programme of this group is complimentary to local children and young people’s partnerships already in place, and that these local plans already include a number of common priorities including increasing joint commissioning around early help; early intervention and prevention; improving access to secondary mental health services; access to eating disorders services; and the delivery of our Local Transformation Plans for people with a learning disability and autism.

As a system, we will explore and develop models of direct support for parents, which moves away from a traditional clinical model to one which improves access to early help, and reduces over time the demand on secondary mental health services across the ICS. This work will be complementary to the work being led through our MH programme on improving access to secondary services, ensuring the offer for children and young people are developed in a way that considers the whole child and their families/carers, and which reduces unwarranted variation.

We are seeking to engage with children, young people and their parents and carers in a variety of ways, and on a range of subjects to inform our decision making and in line with our explicit commitment to co-production. We will seek to also engage with a wide range of partners including education colleagues recognising the significant role that education providers play in early identification of need and support in the improvement of outcomes for children and young people.
Deliverables
As a system we will ensure there is a strong focus on supporting the good physical health and wellbeing of our Children and Young People (CYP) and a commitment to ensuring that all elements of a child’s health needs are considered. We have set system priorities which will support local place based collaborations to jointly plan and develop integrated services for CYP in Hampshire, Surrey and East Berkshire.

Resourcing to support the programme
• A proposal for ICS transformation funding to support the programme including a programme lead and project roles

Building the knowledge base
• Quantitative data collation for CYP health needs - including engagement with Public Health England to undertake a ‘School Readiness’ data pack for ICS as a baseline
• Qualitative assessment of health and wellbeing in CYP – neuro-diverse children and young people - to understand what these children and their families feel are the big health and wellbeing issues and solutions for them. This may require additional investment to fund this activity

CYP focus to existing Prevention and Self care (P&SC) projects
• Extend CYP focus to work of P&SC Programme e.g. asset mapping, social prescribing, MECC, physical activity, social campaigns

Parental health literacy
• New piece of work to assess parental health literacy and then put in place a training programme to address identified needs. Likely to be 2 years duration with evaluation at e.g. 18 months before full roll-out: i.e. Business case, secure programme, implementation and evaluation

Urgent and Emergency Care
• Interpret the health needs assessment and mapping of current services to develop a project initiation document for a programme of work to be delivered over the next 1-3 years. The aim being to target our activities on the specific gaps and areas for improvement in primary and community urgent and crisis services

Neurodiversity
• Develop a shared vision for transforming universal and specific services to cater for the needs of a neurodiverse child and adolescent population and to develop a coherent neuro-developmental pathway for children and young people to include early identification and ongoing support post diagnosis
• Development of a business case for a responsive support programme for families and schools at the first identification of neurodiversity, support/adaptation needs including the adoption of a screening profile tool. This will be piloted in one locality during 2019-20
• Raise awareness of the cultural change required, particularly with schools and families
How will services look by the end March 2020?

Children and young people will have access to earlier interventions and support, and will report feeling more confident that they know where to go if they need advice, or help. There will be better links between organisations and professionals e.g. GPs, hospitals, schools and community providers which will improve the reported experience of families and young people.

A collaborative system approach and the introduction of new and innovative approaches will offer opportunities for the development of the workforce, and will optimise the skills of the current workforce. Where appropriate we will explore the development of new roles which sit across traditional organisational boundaries which are children and young people centric.

Outcomes and Benefits (expected over lifetime of programme)

- Reduction in the numbers of children and young people inappropriately attending or accessing urgent care services in crisis or with non urgent conditions
- Increased self reported satisfaction by CYP on access to advice and support
- Positive impact on the behavioural drivers for patients (parents) seeking a health care consultation and remove the perceived health threat for common child health illnesses
- Proactive management of care closer to home to maintain a better connection with their families and friends, and improve how they interact with local services
- A reduction in the numbers of children and young people referred for secondary ASD/ADHD services

Key Risks and Mitigation

- Without sufficient dedicated roles the programme will not achieve its aims. This will be mitigated through the allocation of ICS transformation funding to the programme
- Planning for CYP’s services takes place across different geographies including Hampshire and Surrey County wide plans. There is a risk that competing priorities will reduce delivery and impact. To mitigate this risk the Children and Young People ICS Steering Group members will commit to promoting the ICS priorities at a local level
- Recruitment and retention of staff remains difficult. Providers are investigating different ways of recruiting and utilising available skills and workforce to deliver services
- Engagement with schools and other agencies is an essential part of the success of this programme. Schools representation to form part of the steering group
## Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| **Neighbourhood**| ~50k      | • Increased self reported satisfaction by CYP and their parents/carers on access to advice and support  
• Increased use of local community assets through social prescribing  
• Integrated health and care commissioned support for services needed by children and young people | • Reduction in numbers of referrals for secondary ASD/ADHD services  
• Move from a medical model to strengths based approach  
• Improved access to information for CYP, parents and professionals to inform decision making |
| **Place**        | ~250-550k | • Positive impact on the behavioural drivers for patients (parents) seeking a health care consultation and remove the perceived health threat for common child health illnesses  
• Proactive management of care closer to home to maintain a better connection with their families and friends, and improve how they interact with local services leading to improved patient experience | • Increase the proportion of self-care dispositions from 111 from the baseline by 10%  
• Reduction in 111 dispositions to same day face-face primary care  
• A reduction in the numbers of children and young people referred for secondary ASD/ADHD services |
| **System**       | 1m+       | • Expanding timely, age-appropriate crisis services will improve the experience of children and young people and reduce pressures on accident and emergency (A&E) departments, paediatric wards and ambulance services  
• A system that promotes the mental and emotional health and resilience of children and young people | • Reduction in the numbers of children and young people inappropriately attending or accessing urgent care services in crisis or with non urgent conditions  
• Improvement in waiting times for secondary ASD/ADHD services  
• Upskilling of the current workforce |
Children and Young People

### Milestones

<table>
<thead>
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<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Funding approval from Programme Delivery Board (PDB) for dedicated programme resources to support the group</td>
<td>• Funding identified and Qualitative assessment completed of health and wellbeing in CYP including neurodiverse children and young people</td>
<td>• Coherent neuro-developmental pathway for children and young people developed, to include early identification and ongoing support post diagnosis</td>
<td>• Business case completed and presented to PDB for a responsive support programme for families and schools at the first identification of neurodiversity, support/adaptation needs including the adoption of a screening profile tool</td>
</tr>
<tr>
<td>• CYP focus extended to work of ICS Prevention and Self care Programme</td>
<td>• Business case to expand social prescribing/community assets model to cover CYP presented to PDB</td>
<td>• Business case to create a parent health literacy programme produced</td>
<td>• Parent health literacy programme implemented</td>
</tr>
<tr>
<td>• Baseline established of CYP health needs - including engagement with Public Health England to undertake a ‘School Readiness’ data pack for ICS</td>
<td>• New piece of work to assess parental health literacy initiated</td>
<td>• Future optimum urgent care pathways and models completed, and associated business cases produced for recommendation for approval at PDB</td>
<td>• Implementation initiation of urgent care pathway changes</td>
</tr>
<tr>
<td>• Project initiation document completed for programme of work to map demand and assess baseline of current urgent and crisis care services for CYP with respective sub group established</td>
<td>• Shared vision developed for transforming universal and specific services to cater for the needs of a neurodiverse child and adolescent population</td>
<td></td>
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</tr>
<tr>
<td>• Sub group established to lead neurodiversity work stream</td>
<td>• Gap analysis for urgent and crisis services completed and priority next steps presented to the CYP and UEC Programme Boards</td>
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</table>
Aim
This programme aims to improve the survival rates and experience for our patients living with and beyond with cancer across the ICS. This will be achieved by working in partnership with our cancer Alliances to achieve the national cancer strategy 2020 targets and to meet the terms of our NHS England Memorandum of Understand (MOU). We will focus on utilising the resources available to provide high quality cancer pathways with seamless integration throughout the patient journey.

Description
The Frimley system faces two Cancer Alliances: Thames Valley and Surrey & Sussex. Building from the requirements of the national cancer taskforce strategy, the ICS has defined a number of key local objectives and deliverables that will improve the lives of cancer patients within the system. The strategy is designed to increase and improve prevention, speed up diagnosis and treatment. To improve the experience of patients and to help people living with and beyond cancer. There are a number of key objectives for this programme that include:

- Earlier diagnosis of cancer through the improvement of screening rates and the implementation of a vague symptoms pathway
- Improved end to end pathways designed to achieve the new national 28 day standard and improve all tumour site performance towards constitutional standards
- Consistently deliver all elements of the recovery package (including stratified follow up pathways) across the system and consider how rehabilitation services at scale could provide additional support to those living with and beyond cancer
- Targeted treatment to improve the quality of life of people living with cancer
- Development of a system-wide Health Information Exchange providing a Cancer Health Record to facilitate better patient care and experience of the service

Earlier diagnosis will be achieved through an increase in the proportion of cancers diagnosed at stage 1 and 2, and will lead to a reduction in the proportion of cancers which present as an emergency with better one year survival rates for all cancers. Enhanced diagnostic capacity and pathways will also help to improve diagnosis rates. In practice this will involve increasing the coverage of NHS Cancer Screening rates for breast, bowel and cervical cancers and the implementation of a pathway for patients with non-specific symptoms of possible cancer, to improve diagnostic accuracy at an early stage. Earlier diagnosis will be realised as commissioning and provider partners within the system identify and address areas of need. There has been extensive discussions between providers, local and national commissioners and the Thames Valley Senate about investing in a linear accelerator on the Wexham Park Hospital site. Progress towards this particular development has been extremely challenging, but will help to support a number of the key elements that have been specified in the cancer plan and the requirements outlined in our MOU for moving forward to an ICS for the system partners.

Improving support for people living with and beyond cancer will be achieved through an enhanced recovery package which includes the effective use of holistic needs assessments and treatment summaries, and improved quality of Cancer Care Reviews (CCRs) helping to tailor services towards individual patient needs. These measures will be effective in meeting both national and Alliance deliverables. A third key aspect of this programme is the further development of risk-stratified follow-up pathways in which patients who have completed their acute treatment then follow a self-management rather than a professionally-led pathway. We will implement these developments through the introduction of a prostate cancer stratified pathway and work towards further pathways in other tumour groups.
Description
The work is led by the ICS Cancer steering group. This group is made up of stakeholders from primary and secondary care, commissioners, both Cancer Alliances, Macmillan Cancer Support, and Cancer Research UK. The group has been established to provide leadership and a collective vision for cancer in the ICS and to work in partnership to deliver improved outcomes. This work is supported by each organisation and by national cancer transformation funding and aims to share best practice, innovation, and learning across and beyond the ICS. The group is supported by a patient reference group.

Deliverables
Note: These are subject to amendment once national cancer transformation funding allocation and deliverables have been clarified and passed down from the Surrey and Sussex Cancer Alliance.

There are a number of key deliverables of this programme that will allow the identification of improvement across the cancer agenda. The steering group has identified 4 workstreams. Prevention and Early Diagnosis led by a CCG manager aims to reduce incidence and late stage diagnosis. The Treatment and Care workstream is led by the acute trust cancer manager and aims to ensure that end to end pathways are streamlined and adapted to reduce the time to diagnosis. The acute Trust Head of Nursing for cancer and end of life care leads the Living With and Beyond workstream, which aims to ensure the recovery package is fully implemented. The Patient Experience and Engagement workstream is led by a CCG manager and aims to ensure that co-creation is used to develop services and that information is available to patients that meets their needs. The team has also committed to develop more meaningful measures of cancer care that track measures other than waiting times. The Informatics project is led separately with input from the cancer teams. The system will continue to deliver the constitutional wait time standards. Specific aims for 2019-20 are as follows:

Prevention and Early Diagnosis
• Support increases in uptake of national screening programmes according to locality need
• Ensure that the deliverables of the Thames Valley Cancer Alliance Transformation Programme/Early Diagnosis workstream are met and provide representation and report to the appropriate working groups in the Alliance
• Support engagement and delivery for the Surrey and Sussex Cancer Alliance prevention and early diagnosis plans
• Monitor progress of CCGs against the 2020 national must dos relating to prevention and early diagnosis as part of the implementation of the National Cancer Strategy
• Ensure implementation of a vague symptoms multi-diagnostic pathway in the north of the ICS, and plan for this pathway to be rolled out across the south of the ICS, as well as rolling out the FIT test for symptomatic patients
• Work with public health to support prevention activities (including national targeted lung health checks programme if applicable in this year)

Treatment and Care
• Oversee an on-going project plan to deliver improved cancer pathways for each tumour site and diagnostics services
• Identify actions required to achieve 28 days to diagnosis standards and implement these (including collection of mandatory data from April 2019)
• Ensure appropriate direct access to diagnostics according to NICE guidance, make recommendations regarding the introduction of new tests
Cancer

Deliverables

Living with and Beyond Cancer:
• Implementation of all parts of the recovery package
• Maximise opportunities for self-management and surveillance as close to home as possible through roll out of risk stratified pathways in prostate and colorectal cancer
• Increase in patients receiving a Treatment Summary for eligible patients
• Increased proportion of patients receiving an Holistic Needs Assessment (HNA) and care plan within 31 days
• Increase in patients who receive a Cancer Care Review (CCR) and improved quality of CCRs.
• Devise a menu of options for patients to access support and signposting through events held at different times, locations with both general and tumour site focus
• Increase in the number of patients accessing holistic information and support through Health and Wellbeing Events
• Macmillan supported pilot in NEH&F and SH for community cancer navigators to signpost people to services to support their health and wellbeing

Patient experience and engagement
• Review the National Cancer Patient Experience Survey results, views of the Cancer Alliances and local intelligence and use this to devise improvement programme regarding patient experience
• Involve patients in design of health and delivery of health and wellbeing events
• Ensure patient representation on the ICS cancer steering group
• Undertake assessment of patients’ information needs and deliver these

Health Information Exchange (HIE)
Underpinning the delivery of the programme objectives is the development of a system-wide Health Information Exchange (HIE). Aligning with the broader ICS digital strategy and the Local Digital Roadmap (LDR), the adoption of the HIE will help to deliver integrated records for cancer patients within the system helping to facilitate improved patient care through more accurate and detailed information made available to the appropriate health care professional at any stage of the patient pathway. Access to such information will allow the health care professionals to better support our cancer patients throughout their pathways thus helping to improve the quality of life and patient experience for our patient population following cancer diagnosis and treatment.

Strategy
The ICS cancer steering group will devise a 5 year plan for cancer during 2019.
How will services look by the end March 2020?

**User experiences:** Patients will receive a diagnosis or have cancer ruled out within 28 days of suspected cancer referral being received. They will receive treatment in a timely way as close to their home as possible. They will receive an assessment of the needs early on in their pathway and a review in primary care after treatment has been completed. Patients will be able to access a variety of events and information to enable them to live as well as possible during and after treatment, and to signpost them to other services that may be appropriate. Some patients will have the opportunity self-direct their follow up post treatment.

**Workforce changes and experience:** There will be more cancer clinical nurse specialists with further training available, and those nurses will be augmented with cancer navigators to deliver better and more targeted care. This will improve the cancer support nurses working lives.

**System changes:** If a GP has a suspicion that a patient may have cancer but they do not fit the NICE referral criteria, they can request urgent assessment via a vague symptoms pathway. There will be closer working between CCGs, providers and public health to deliver improved cancer outcomes. Information regarding patient care will be easily shared amongst relevant professionals.

**Outcomes and Benefits**

- Patients have an earlier diagnosis of colorectal cancer through use of symptomatic FIT test
- Improved health outcomes: Patients have sufficient time with professionals at key touch points to identify and support their needs
- Improved 5 year survival rates (particularly for lung cancer)
- Improved diagnosis at stage 1 & 2 and improved 1 & 5 year survival
- Patients experience faster treatment leading to improved survival and patient experience
- Improved health outcomes through increased use by patients of self management options
- Improved patient experience and support
- Access to rapid diagnostic pathway for patient with vague symptoms
- Reduction in patients diagnosed at emergency presentation
- System-wide pathways delivering diagnosis within 28 days of referral
- Menu of health and wellbeing events, and signposting for those living with and beyond cancer
- Agreed plan to improve access to and uptake of radiotherapy

**Key Risks and Mitigation**

- Secondary care overwhelmed with increased demand in the vague symptoms pathway mitigated by close working with pathfinder team at Oxford to learn form their experiences of implementing a manageable pathway
- Engagement with public health to deliver improved prevention – mitigated by inviting PH representative to the ICS cancer steering group
- Diagnostic capacity to be mitigated by ICS diagnostic capacity review
- Workforce, mitigated by work with NHSE to develop future workforce and partnership with Macmillan to support individual and team development
- Limited primary care resources to implement and support patients on stratified follow up pathways both short and long term. This risk to be mitigated by ensuring primary care are involved in the development of pathways and to identify any relevant funding streams and self sustaining processes
- Some patients experience difficult access to radiotherapy services which will be mitigated through discussions with relevant service providers
## Cancer Outcomes and Benefits

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| Neighbourhood | ~50k      | • Patients have an earlier diagnosis of colorectal cancer through use of symptomatic FIT test  
• Improved health outcomes: Patients have sufficient time with professionals at key touch points to identify and support their needs |                                   |
| Place         | ~250-550k | • Improved 5 year survival rates (particularly for lung cancer)  
• Improved diagnosis at stage 1 & 2 and improved 1 & 5 year survival  
• Patients experience faster treatment leading to improved survival and patient experience  
• Improved health outcomes through increased use by patients of self management options  
• Access to rapid diagnostic pathway for patient with vague symptoms |                                   |
| System        | 1m+       | • Improved patient experience with cancer services  
• System-wide pathways delivering diagnosis within 28 days of referral  
• Reduction in patients diagnosed at emergency presentation |                                   |
# Cancer

## Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Measures of cancer care agreed and monitoring process in place</td>
<td>• Progress with screening plans reviewed</td>
<td>• National timed pathways for suspected upper GI and lung cancer implemented</td>
<td>• Vague symptoms pathway at Frimley Park Hospital implemented</td>
</tr>
<tr>
<td>• Q1 Report completed (all data items in the 28 day faster diagnosis standard)</td>
<td>• Project initiated for vague symptoms pathway at Frimley Park Hospital (pending S&amp;S Cancer Alliance funding)</td>
<td>• Risk stratified follow up pathway for colorectal cancer implemented</td>
<td>• Health and wellbeing event menu developed and in place</td>
</tr>
<tr>
<td>• Record sharing between Cerner and Graphnet in place to support record sharing with the tertiary centres in the north</td>
<td>• Patient information needs assessment completed (pending Alliance funding)</td>
<td>• Two health and wellbeing events delivered</td>
<td>• Health Information Exchange Website revised to provide patient focused information</td>
</tr>
<tr>
<td>• Agreed plans for LINAC in partnership with provider cancer centre, supported by specialist commissioners</td>
<td>• Increase in health needs assessments, treatment summaries and cancer care reviews delivered</td>
<td>• Symptomatic FIT testing roll out initiated</td>
<td>• Deliver agreed screening targets</td>
</tr>
<tr>
<td>• Prevention plans agreed with public health and ICS partners</td>
<td>• Actions agreed as result of the national cancer patient experience survey implemented</td>
<td>• 5 year plan for cancer agreed</td>
<td>• Work with Genomic Laboratory Hubs to implement the national genomic test directory, having patient choice offer and fresh-frozen pathways in place</td>
</tr>
<tr>
<td>• Screening targets agreed and locality actions initiated</td>
<td>• One health and wellbeing event delivered</td>
<td>• Symptomatic FIT pathway roll out initiated</td>
<td>• Support delivery of regional plans for implementation of phase 1 of the cancer workforce plan once the plan is known</td>
</tr>
<tr>
<td>• National timed pathway for suspected colorectal and prostate cancer implemented</td>
<td>• All referrals for suspected cancer follow NICE guidance and are being sent via the e-referrals system with all the appropriate information required</td>
<td>• Direct access to diagnostics review initiated</td>
<td>• One health and wellbeing event delivered</td>
</tr>
<tr>
<td>• Stratified follow-up pathway for prostate cancer initiated</td>
<td>• Vague symptoms pathway at Wexham Park Hospital implemented</td>
<td>• Prevention plans implemented</td>
<td></td>
</tr>
</tbody>
</table>
**Aim**
To work together as a whole system to create a consistent, cost-effective, evidence-based approach to medicines optimisation, leading to improved outcomes for our local people. The focus for 2019-20 will be to build on the initial scoping work undertaken in 2018-19 across the system and to establish an ICS wide Medicines Optimisation Board to ensure consistent, robust decision making in relation to medicines and appliances.

**Description**
The focus of the Medicines Optimisation work stream is to improve health outcomes from medicines and ensure that we are getting the best value from the Frimley Health and Care ICS medicines bill. Medicines Optimisation is ensuring that patients are being prescribed appropriate medicines, that these are being taken correctly, that unnecessary medications are avoided, wastage is reduced and patients' safety is improved. Opportunities exist to deliver medicines optimisation at a larger scale across the system by reducing clinical variation and duplication of effort but still retaining the value of local relationships.

A key enabler to the delivery of the work stream is to establish a collaborative Medicines Optimisation Board for the ICS, whose functions will include decision making, advice and support regarding the introduction of new medicines and prescribed items (including appliances), medicines optimisation, maintenance and updating of the Joint Frimley Health formulary, support of Right Care priorities and the priorities of the ICS in relation to medicines. The use of IT and data analysis is also a key enabler and therefore we will investigate how we access and share information across the system.

The Medicines Optimisation work stream will work closely with the other work streams particularly the Reducing Clinical Variation sub-groups; respiratory, musculoskeletal (MSK), circulatory, diabetes, gastro-intestinal, neurology to ensure that medicines optimisation is included in the re-design of services and patient pathways and the Care and Support work stream to improve medicines use in care homes and support the care homes pharmacists and pharmacy technicians.

In order to identify the priority areas to focus on, we have decided to concentrate on the ‘Optimising the use of medicines’ work stream from the NHS England Medicines for Value Programme:

- Improving patient safety
- Improving health outcomes from medicines through improving patient information, making best use of the clinical skills of pharmacists and pharmacy technicians, and implementing clinically effective prescribing and medicines reviews.
- Increase use of the best value biological medicines (including biosimilars) and generic medicines
- Dose-banding – starting with chemotherapy
- Reducing waste
- Reducing inappropriate polypharmacy – especially in care homes
- Reducing the prescribing of clinically- or cost-ineffective drugs (items of low priority and over the counter items)
- Reducing anti-microbial resistance
Deliverables

- The establishment of an ICS Medicines Optimisation Board to deliver system leadership in medicines use
- Improving patient safety
  - Transfer of Care Around Medicines (TCAM)-Referral of patients post discharge from FHFT to community pharmacy for medication usage reviews or new medicines service via Pharma Outcomes
  - Implementation of risk stratification tools such as PINCER and/or Optimise Rx to reduce the number of medicines-related patient safety incidents which can lead to hospital admissions
  - Reviewing the current shared care arrangements across the system to improve the management of high risk drugs
  - Identify the prevalence of high dose opioids usage and work with the MSK Pain sub-group to reduce inappropriate prescribing
- Improving health outcomes from medicines through improving patient information
  - Developing medicines information for high risk and complex medicines such as anticoagulants and inhalers for patients whose first language is not English
- Increasing the use of the best value biological medicines (including biosimilars) and generic medicines
  - Implement uptake of the best value adalimumab in line with national targets
  - Develop and implement a system wide policy on generic prescribing
- Dose-banding – starting with chemotherapy
  - Scope the opportunity for dose-banding with infliximab to reduce waste
- Reducing waste
  - Reduce waste in care homes through the Medicines Optimisation (MO) in Care Homes project
  - Improving standards of the Homecare companies
- Reducing inappropriate polypharmacy – especially in care homes
  - Reducing inappropriate polypharmacy in care homes through the MO in Care Homes project
  - Identification of patients prescribed multiple medicines and with chronic or long-term conditions for medication reviews
  - Mapping the use of a screening tool – for example, the STOPP/START tool in older people and adults, children and young people with chronic or long-term conditions.
- Reducing the prescribing of clinically- or cost-ineffective drugs (items of low priority and over the counter items)
  - Implementing across the ICS the NHS recommendations on items of low value/priority and reducing the prescribing of over the counter items
  - Development and dissemination of consistent communications regarding the recommendations
  - Development of a service to manage the prescribing of liothyronine
- Reducing anti-microbial resistance
  - Continue to monitor and reduce the inappropriate prescribing of antibiotics in line with national targets (NHSE Quality Premium)
- Making best use of the clinical skills of pharmacists and pharmacy technicians by mapping the existing workforce across the ICS
Medicines Optimisation

How will services look by the end March 2020?

• Improved patient outcomes as a result of evidence-based medicines optimisation being embedded into the re-design of services and patient pathways. Our population will have equitable access to safe, quality, evidence-based medicines and appliances and support to enable them to take their medicines safely

• All Medicines Optimisation/Medicines Management, GP Clinical Pharmacists and Pharmacy Teams across the system will be mapped out to identify skills and expertise in order to identify gaps and opportunities for shared working. We will engage with the Local Pharmaceutical Committees to identify opportunities for closer and shared working with the Community Pharmacy workforce

• A more integrated approach to medicines optimisation underpinned by a robust, evidence –based approach to decision-making leading to improved patient outcomes

Outcomes and Benefits

Outcome measures will be developed as part of the collaborative planning arrangements but may include:

• Reduction in antibiotic prescribing as specified in NHSE Quality Premium
• Increased reporting of medicines related incidents through a standardised system to share and learn from common themes
• Improved management of patients prescribed high risk medicines leading to improved patient safety
• Implementation and increased use of a Joint Formulary across the system
• Reduction in inappropriate polypharmacy
• Embedding medicines optimisation into the re-design of services and patient pathways therefore improving patient outcomes
• Reduction in the prescribing of items of low clinical value and low priority thus delivering better value for money within current resources

Key Risks and Mitigation

• Lack of engagement across primary and secondary care and across different geographies resulting in clinical variation. The establishment of an inclusive decision making Medicines Optimisation Board with full stakeholder membership and engagement and credibility is required.
• The prescribing of medicines is commonly omitted when commissioning services and patient pathways thus leading to variation in cost-effective prescribing and sometimes clinical variation. To address this a pharmacist from any of the ICS organisations should be involved in the Reducing Clinical Variation sub-groups.
• In order to deliver an ambitious Medicines Optimisation work plan additional resource is required. An experienced Programme Manager/leader is required to drive the delivery of the plan across the whole system. Experienced administrative support is required to support the new ICS Medicines Optimisation Board, and support the development of the Joint Formulary which is key to improving medicines optimisation across the system
# Medicines Optimisation

## Outcomes and Benefits

<table>
<thead>
<tr>
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<th>Pop. Size</th>
<th>Outcomes</th>
<th>Benefits (Financial and Workforce)</th>
</tr>
</thead>
</table>
| Neighbourhood  | ~50k      | • Patients have greater awareness of self care of minor infections; reduced exposure to side effects of unnecessary antibiotics  
• Greater patient understanding of medicine’s use including multiple medicines  
• Access to effective biosimilar medicines  
• Improved use of self care, management and understanding of own medicines (incl. care home residents), own health and personal care  
• Patients experience reduced risk from medicines taken - improved quality of care | • Reduction in antibiotic prescribing  
• Improved transfer from acute setting back to home; person knows which medicines they take and why; reduced delays in discharge related to medicines |
| Place          | ~250-550k | • Reduced antimicrobial resistance  
• Improved quality of care  
• Improved access to services  
• Improved quality of care/health outcomes for Care Home residents | • Improved antibiotic prescribing  
• Decreased admissions due to opioid related side effects  
• Improved information regarding medicines following transfer from acute setting back to home; primary care team knows which medicines a person takes and why; reduced delays in discharge related to medicines |
| System         | 1m+       | • Improved quality of care by using dose banding  
• Improved quality of care  
• Implementation of joint formulary to ensure equity of access for people across ICS | • Reduction in antibiotic prescribing resulting in reduced bacteraemias and decreased antimicrobial resistance  
• Reduced clinical variation from consistent prescribing in line with joint formulary  
• Improved cost effectiveness of care through use of biosimilars  
• Reduced variation for prescribing of over the counter (OTC) medicines, low clinical value medicines and high dose opioids |
# Medicines Optimisation

## Milestones

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
</table>
| • Adalimumab Biosimilar Implementation  
• OTC and first phase Low Clinical Value Medicines messaging with all ICS stakeholder organisations identified action plan completed and implemented  
• Medicines Optimisation Board for Frimley ICS held  
• Baseline audit of high dose opioids completed by all stakeholders  
• Growth areas of drug spend in all ICS stakeholder organisations identified | • Adalimumab Biosimilar Implementation Workstream Programme Manager and support posts recruited to  
• Q2 monitoring of Adalimumab Biosimilar implementation completed  
• OTC and first phase Low Clinical Value Medicines messaging with all ICS stakeholder organisations identified action plan reviewed  
• Second phase NHSE Low Value Medicines Consultation – action plan to be completed and implemented  
• Evaluation of MOCH interventions and waste savings completed  
• Growth areas of drug spend in all ICS stakeholder organisations reviewed  
• Potential opportunities for dose banding identified  
• TCAM project action plan to be completed and implemented  
• PINCER Project action plan to be completed and implemented | • Q3 monitoring of Biosimilar Adalimumab implementation completed  
• OTC and first and second phase Low Clinical Value Medicines messaging with all ICS stakeholder organisations identified action plan review  
• Prescribing review of high dose opioids in line with baseline audit, completed. Further areas of variation identified  
• Growth areas of drug spend in all ICS stakeholder organisations reviewed  
• Medicines Optimisation Board review of progress and horizon scanning opportunities for 2020-21 completed  
• Process agreed with all ICS Stakeholder organisations for identifying and reviewing people on multiple medicines who would benefit from polypharmacy/ prescribing reviews  
• TCAM project action plan to be reviewed  
• PINCER Project action plan to be reviewed | • Q4 monitoring of Biosimilar Adalimumab implementation completed  
• OTC and first and second phase Low Clinical Value Medicines messaging with all ICS stakeholder organisations identified action plan review  
• Mapping of Medicines Optimisation workforce and wider networks completed  
• Progress and delivery of MOCH interventions and waste savings evaluated  
• Frimley ICS Joint formulary for all prescribed items developed  
• Mapping of shared care in relation to prescribed items within Frimley ICS completed  
• Streamlining of Antibiotic/Antimicrobial Stewardship CQUINs and Antibiotic QP completed to ensure ICS approach to Antimicrobial Stewardship  
• TCAM project action plan to be reviewed  
• PINCER Project action plan to be reviewed |
Our People Strategy

We recognise that recruiting and retaining the workforce we need is one of our most significant challenges and we will need creative and affordable solutions. ‘Reshaping our workforce to deliver the ICS vision and achieve a sustainable workforce fit for the future’ (Workforce Strategy) was developed in conjunction with Health Education England in order to increase our understanding of the workforce implications of the Frimley system vision. The strategy was informed by the workforce priorities identified in each transformation and cross cutting programme encompassing both the health and care workers. Our People Strategy encompasses the following elements:

- **Workforce Planning:** Create sustainable system performance by providing the basis for decision making about our future workforce needs
- **Organisational (system) and Leadership Development:** Support the making and managing of the behavioural changes we need to make as a system
- **Human Resource Management:** Ensuring we have the technicalities of the employment cycle in place to ensure the system has the “right skills, in the right place at the right time” including new mechanisms to increase flexibility between organisations

### Challenges

The South East of England (SEE) is located is an area with relatively high cost of living where it can be difficult to recruit and retain staff. Our workforce is ageing, with:

- Across Frimley ICS, 20% of GPs and 44% of practice nursing workforce being 55+
- Across SEE, 2% of the community health workforce, with 22% of social care workers in local authority and private sector settings are aged 55+
- Many practices are struggling to recruit practice nurses, salaried GPs and partners, with younger GPs reluctant to invest in surgery buildings
- The number of GPs and community nurses/1000 population is lower in our footprint than the national figure, and significantly lower in East Berkshire
- Emerging competency gaps and increasing problems with recruitment and retention in the domiciliary and care home markets in the SEE workforce (1:3 nurses are over 55 years and turnover is 34%, and a third of all care workers receive no regular and on-going training)
- Shortages in medical workforce in key areas (e.g. Acute Medicine, Stroke, Elderly Care) and a heavy reliance on (often high cost) medical locums across the acute sector
- Attracting sufficient supply of nurses, midwives and allied health professionals to meet demand in the acute sector is challenging and turnover is around 15%
- The care home market has relatively poor CQC ratings (47% inadequate or requires improvement)
- There is a growing lack of confidence in the provider market’s ability to deliver the Care Act particularly given the likely impact of demographic changes
- There is a sharp increase in demand for mental health services with major interventions requiring a reshaping of the work force to manage the demand
- People are used to working within organisational rather than system frameworks

### Approach

We are ensuring our system and its leaders are ready to deliver cohesive change. This is a major undertaking and is focusing on a number of key areas of support to our staff.

Ensuring our teams and those in the wider system are prepared and able to deliver care is crucial to the success of the ICS. The system is encouraging staff to work differently and more jointly to enable better and more seamless care and support for our population. As well as improving workplace wellbeing, we have clear ambitions to enhance the ability of our teams and our voluntary sector and wider partnerships to deliver care differently. We are supporting them through a range of initiatives (social prescribing), including specific development courses, local development workshops and deploying an implicit set of values to reinforce joint working in everything we do across the system.

Our staff are being supported in career progression/portfolio careers programmes maximising use of the apprenticeship levy. New roles are being developed to replace or support hard to fill roles including nursing associates and advanced clinical practitioners. Our shared workforce plan increases opportunities for rotation across organisations, giving staff greater experience and enabling them to deliver better care by working more effectively around the individual rather than within organisational boundaries.
The ICS vision is clear - whatever the individual’s need, staff throughout the care system will give greater support for individuals to take responsibility for their own health and care. This has substantial implications for the health and social care workforce in every organisation across Frimley Health and Care including the voluntary sector, informal networks and carers.

### Workforce Planning: Vision and Deliverables

- **Six System Wide Principles**
  - Securing the supply of staff the health and care system needs to deliver high quality care in the future
  - Training, educating and investing in the workforce to give new and current staff flexibility and adaptability
  - Providing broad pathways for staff so they have careers, not just jobs
  - Widening participation in NHS jobs
  - Ensuring that the NHS, and other employers in the system, are model modern employers
  - Ensuring that in future service, financial and workforce planning are properly joined up

- **Workforce Deliverables**
  - Our plans during 2019-20 and beyond include:
    - New skills development in non-clinical patient facing roles
    - A local workforce strategy for general practice aligned with the new National 5 year contract for general practice
    - Support programmes designed with delivery plans for the retention of both newly qualified GPs and experienced ones
    - New employment arrangements explored across all health and social care providers to develop career paths into nursing and allied professional roles with rotation across sectors, allowing us to optimise the current workforce without staff needing to move organisations in particular honorary/ licence to attend or other contractual arrangements to provide flexibility across the system
    - Pre-employment checks/mandatory training requirements applicable cross organisations
    - Medical staff recruitment ‘hotspots’ regularly reviewed, identifying areas of need and mitigating agency spend. Optimise use of acute trust bank for medical staff to fill empty shifts, maximise savings from direct engagement and reduce standard rate of pay for locum staff through agencies. Work with recruitment partner to fill high cost locum posts
    - Agreed delivery mechanisms across all recommendations within the Workforce Strategy, both cross-organisational and organisational actions
    - Include workforce metrics information as part of our system dashboard
    - Acute trust signed up to NHSI Retention Support Collaborative for focused programme on improving nursing and midwifery retention with intent to use learning to improve retention elsewhere in the organisation
    - International recruitment strategy to be continued in the acute sector, with a minimum of 150 new nurses due to commence during 2019-20

### Key actions from the Workforce Strategy

- Changing the GP, nurse and multi-disciplinary team ratios in primary care to address the ageing profile of this workforce
- High impact actions to address turnover in the support workforce, including market mechanisms
- Rapid development of multi-disciplinary working to increase the impact of proactive care initiatives
- Strengthening retention and recruitment initiatives across the system, including developing a ‘whole system approach’ to supply improvement actions
- An action plan to capture these system-wide objectives
- Agree a small number of system wide workforce tracking metrics

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**7**

**ASCOT • BRACKNELL • FARNHAM • MAIDENHEAD • NORTH EAST HAMPSHIRE • SLOUGH • SURREY HEATH • WINDSOR**
Frimley Health and Care recognises that in order to deliver more seamless care and improved health outcomes, everyone within the system (circa 40,000) needs to work differently. Our ambition is to nurture leaders in every part of our health and care system, equipping and supporting them to work across organisational and professional boundaries to make a difference for local people and communities.

**Leading System Development**
Building trust and strong relationships is essential to system wide working. The ICS Board has worked closely with the King’s Fund and facilitation partner Co Create to build on the trust and shared responsibility across our top leadership team required to tackle the tangible challenges faced by our system.

**System Design**
During 2019-20, we will design our system architecture and the development support that will be required to embed new ways of working and level 3 self assurance responsibilities. This will build on our local Memorandum of Understanding (MOU) and will be developed in partnership with our regulators. This is part of our commitment to keep moving towards primacy of the system amongst the ‘coalition of the willing’, and ensuring that there is strength of empowered and aligned decision-making at system, place and in local neighbourhoods and communities.

**Supporting System and Leadership Development**
The Frimley Leadership and Improvement Academy (FLIA) was established in May 2018 providing oversight and expertise to ensure the right portfolio of leadership programmes are in place. All our programmes will be designed to enable staff to work collaboratively and lead change at any level within the system. Our Improvement Network (IN) will draw from people across the system with improvement skills and expertise and will:
- Offer guidance and mentoring in Quality Improvement (QI) approaches
- Cascade the development of system leadership and QI skills, tools, mind sets and behaviour across the ICS
- Connect people working on improvement across the system
- Establish and grow a library/knowledge bank of quality improvement best practice

Best organisational development (OD) practice will be shared and developed within the ICS and across other systems through the Frimley OD Network.

**System and Leadership Development Deliverables**
- Establish the governance and resource for system wide Organisational/Leadership Development
- Develop an ICS Organisational Development, Leadership and Improvement Strategy to include values and behaviours and establish the skills, capabilities, competencies and behaviours our staff across the system need to demonstrate
- Develop a plan to communicate the above and embed them into organisations
- Develop a talent management programme in line with the emerging talent management architecture, including the establishment of an ICS Talent Board
- Develop a whole system approach to Quality Improvement
- Agree where organisations can collaborate in the delivery of leadership development and other core learning and development programmes
- Recruit to and promote take up of the support from the Improvement Network
- Evaluate existing system wide programmes and undertake a gap analysis, identifying where new and existing programmes could contribute to the delivery of the strategy
- Agree a framework for the development of new programmes as necessary
- The leadership role for general practice within Primary Care Networks will be supported through a national network development programme with bespoke local support
Human Resources Programme

Within this programme we are working to understand and determine human resources (HR) and workforce priorities, strategies and action plans to support the delivery of the ICS transformation programme. We aim to ensure that we create the legal and operational HR infrastructure to fully support all aspects of the employment cycle across the ICS to facilitate the system in delivering the “right skills, in the right place at the right time”. This includes new mechanisms to enable flexible cross organisational working, shared recruitment campaigns, together with identification of HR priorities and sharing of HR knowledge and best practice.

Achievements in 2018-19

Our focus during 2018-19 was on addressing system mobility, specifically facilitating integrated team working, cross organisation working and recruitment efficiencies. We have a pan ICS team in place which has developed a draft Working Together Framework Agreement Contract to allow cross boundary ICS working. Together with BOB and Surrey Heartlands we have agreed to streamline inter NHS recruitment across all three systems partners. With the support of the major ICS employers work has commenced on developing an ICS identity to facilitate the delivery of ICS wide recruitment campaigns. Our greatest achievement is creating inter-organisational HR networks across the ICS who understand the importance of the work of the ICS and will practically support the HR delivery of the overall ICS workforce transformation.

Challenges

Within the ICS we have three interrelated challenges driven by the fact that nationally and locally there are insufficient qualified/ key workers available to fill available vacancies. The impact of this is:

- Workforce is singularly the biggest risk for the NHS at a national and organisational level. HR colleagues around all ICS organisations are under enormous pressure to deliver services in support of their local workforce. HR resources are fully stretched with little capacity to deliver in addition to their current workload
- Competition for the same resources between neighbouring systems with the same providers
- IT and IG issues also impact on the ability of HR to deliver support across ICS organisation boundaries as this can limit access to each other’s networks

Approach for 2019-20

- Developing and deploying the resources to support the Working Together Framework Agreement
- Extend the Working Together Framework Agreement to other ICS partner organisations e.g. GPs. Third Sector etc.
- Developing an ICS recruitment identity, benefits , assets and shared approach to recruitment
- Subject to a technical feasibility study set up a branded Frimley Health and Care ICS hosted recruitment portal
- High level analysis of ICS partner recruitment, agency and retention data as the basis considering an ICS wide recruitment and retention programme
- Initial event to examine the feasibility of shared recruitment and retention programmes
- Explore the extension of ICS rotation programmes beyond apprentices e.g. grads, students, OTs, cancer navigators etc.
- Developing ICS wide alternative skill mixes for hard to fill roles
- With BOB and Surrey Heartlands implement a collaborative approach to recruitment streamlining ready for a pilot of the August 2019 Junior Doctor rotations
- Extending a new way of working and operating across different providers and systems beyond the Frimley ICS
- Provide cross organisation HR support to facilitate ad hoc workforce change programmes/initiatives. E.g. HR approach to shared procurement activities e.g. legal services
Digital and Technology

We aim to provide a digital ecosystem that enables our staff and residents to make best use of technology, share information to inform clinical and professional decision making, and underpin our analytics function to provide evidence for best practice. This will align with the Frimley Integrated Care System (ICS) strategy and incorporate industry best practice.

Description
The Frimley ICS Digital Board will continue to focus on the four key areas of connected care that will support the greatest transformation and ensure that the component priorities contribute to the wider digital ecosystem. Three will be delivered through the shared care record workstream and underpinned by Connected Care - record sharing, Person Health Record and an intelligence platform.

Transformation will be at the core of the digital agenda to ensure that care professionals are bought into the digital implementations and benefits are maximised. ICS Digital Board will ensure alignment between digital deliverables and ICS workstream deliverables. This will support investment in digital being targeted in the most effective way and prevent the risk of duplication or inefficient use of funding. The ICS Digital Board will also support alignment of resources in order to ensure priorities are identified within current financial constraint.

In addition, we will align digital strategy, innovation and adoption across a wider footprint into neighbouring systems in order to further support our residents moving across borders, and inform population health and information. Infrastructure and Information Governance will be pivotal enablers in our digital enablement. Our four key areas of focus for the Board are listed below:

Alignment with ICS workstreams
Transformation driving the iterative improvement of core digital programmes such as Connected Care through co-design and care professional working groups. This will support with the alignment with the wider ICS workstreams as there will be cross fertilisation of professionals who are involved in multiple working groups.

Alignment with wider system
We are heavily involved in programmes such as the Local Health and Care Record Exemplar (LHCRE) and Cancer HIE (Thames Valley Cancer Alliance) and as such can ensure that the work we do aligns with the wider system. This includes influencing and supporting single flows of information out of our local systems into Connected Care to support flows out into neighbouring system in a coordinated way.

Information Governance
We have established an IG steering group that will be given the mandate to set key direction for complicated information sharing challenges that are key enablers for better care. The group is an enabler and it’s function is to support information sharing in the most efficient, safe and legal manner with associated governance in place to ensure all partners within the system are confident with how information is shared and used.

Collaborative Infrastructure
To support the workforce, a final priority area is to explore opportunities to align the infrastructure between ICS organisations. This will support professionals communicate more efficiently and ensure we are making the best use of resources. It will also encourage sharing of best practice and more flexible working.
We have had a consistent vision since 2016 around our digital priorities which has allowed us to move forward in a coordinated manner. This has increased the benefits of each component part as each deliver area is interlinked.
Aim
To deliver the ICS estates programme described in the ICS Estates Strategy submitted in the summer of 2018. The Strategy specifically supports the delivery of the Estates Technology and Transformation Fund (ETTF) and ICS business case submissions designed to support the delivery of key transformation programmes across the ICS.

Description
All projects (current and future) are aligned to a key set of principles:

- Estates projects are an important enabler for the system’s vision of people being seen at the right place but the right people and at the right time
- Align with existing local authority and health plans (as set out in the estates strategy)
- Meet our requirements to work within One Public Estate including maximising surplus land for disposal
- Support the delivery of local initiatives to address primary care capacity, non-elective activity and address future growth pressures
- Allow pace to delivery in order to expedite achievement of benefits, and minimise the barriers to delivery, such as major consultation exercises
- Involve limited capital expenditure
- Are set against local and national affordability criteria (as assessed using agreed criteria (VFM, GEM modelling)

The ICS estates programme is set against the deliverables outlined in the ICS Estates strategy submitted in the summer of 2018 which:

- Summarises partner organisations estate programmes
- Describes the enabling programmes designed to support the ICS sustainability and transformation operating plan
- Identifies the disposal opportunities generated by the ICS wide estates programme
- Captures the potential funding streams to support each project

The system wide priorities which provide the context for the estates programme in 2019-20 are:

- **Integrated Care Decision-making (ICDM):**
  - Clarify the clinical requirements of the ICDM programme that will lead to the scale, scope, location and design of the required estate
- **General Practice Transformation:**
  - Confirmation of the current and additional services that will require a different / additional estate footprint e.g. additional locally delivered clinical services
Description

Urgent and Emergency Care:

• Conclusion of the urgent care review across the system – with particular focus on the East Berkshire preferred solution

Acute care re-configuration i.e. Heatherwood and care pathway opportunities this creates:

• Ensuring the estate reflects the new care models the Heatherwood programme develops

<table>
<thead>
<tr>
<th>Programme</th>
<th>Local Initiative</th>
<th>Purpose</th>
<th>Funding Route</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Transformation</td>
<td>Ascot development plan</td>
<td>Increased capacity for Ascot population</td>
<td>ETTF</td>
<td>Outline Business Case Oct 2018</td>
</tr>
<tr>
<td></td>
<td>• Ben Lynwood</td>
<td></td>
<td></td>
<td>Full Business Case Feb 2019</td>
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<td></td>
<td>• Heatherwood</td>
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<tr>
<td></td>
<td>Slough</td>
<td>Co locate with Local Authority services – in line with One Public Estate</td>
<td>ETTF</td>
<td>Outline Business Case Nov 2018</td>
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<td></td>
<td>• Britwell</td>
<td></td>
<td></td>
<td>Full Business Case Feb 2019</td>
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<tr>
<td>ICS Integrated care</td>
<td>North East Hants &amp; Farnham</td>
<td>Creation of integrated care hub</td>
<td>ICS wave 2</td>
<td>Outline Business Case Dec 2018</td>
</tr>
<tr>
<td></td>
<td>• Fleet Community Hospital</td>
<td></td>
<td></td>
<td>Full Business Case March 2019</td>
</tr>
<tr>
<td>ICS Integrated care</td>
<td>Surrey Heath</td>
<td>Creation of integrated care hub</td>
<td>ICS wave 2</td>
<td>Outline Business Case Jan 2018</td>
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<td>• Surrey Heath House</td>
<td></td>
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<td>Full Business Case March 2019</td>
</tr>
<tr>
<td>ICS Integrated care</td>
<td>East Berkshire</td>
<td>Creation of integrated care hubs for each locality</td>
<td>ICS wave 2</td>
<td>Outline Business Case March 2019</td>
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<td>King Edward VII Windsor</td>
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<td>Full Business Case July 2019</td>
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<td>• Slough</td>
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<td>• Maidenhead</td>
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<td>• Bracknell</td>
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<tr>
<td>ICS</td>
<td>Heathlands nursing home</td>
<td>Additional capacity to reduce / prevent acute sector admissions</td>
<td>NHSE</td>
<td>Outline Business Case submitted Sept 2018</td>
</tr>
<tr>
<td>GP Transformation</td>
<td>North East Hants &amp; Farnham</td>
<td>Create additional capacity in primary care</td>
<td>ICS wave 4</td>
<td>Application submitted July 2018</td>
</tr>
<tr>
<td></td>
<td>refurbishment of practices</td>
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</tbody>
</table>
## Estates

### Description

<table>
<thead>
<tr>
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<th>Local Initiative</th>
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<th>Funding Route</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus land disposals</td>
<td>East Berks CCG - Review and declare land surplus to requirements</td>
<td></td>
<td>N/A</td>
<td>Governing Body paper Dec 2018</td>
</tr>
<tr>
<td>ICS Estates strategy refresh</td>
<td>In light of impending funding decisions estates strategy will be reviewed</td>
<td>Ensure strategy up to date and reflective of maturing clinical strategies</td>
<td>N/A</td>
<td>Aug 2019 to ICS board</td>
</tr>
<tr>
<td>Frimley Health NHS Foundation Trust Modernisation programme</td>
<td>Emergency assessment centre</td>
<td>Improve patient flow through Emergency Department</td>
<td>Trust capital</td>
<td>2019-20</td>
</tr>
<tr>
<td>Frimley Health NHS Foundation Trust Modernisation programme</td>
<td>Diagnostic centre</td>
<td>Provide MRI / CT scanning facilities</td>
<td>Trust capital</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Aim
We will develop a vision, framework and programme for system wide quality and a shared commitment to further developing a culture of quality improvement focusing on effective care, safety and ensuring people have a positive experience of care.

Description
In 2019-20 we will focus on making quality everybody’s business and to support the delivery of consistently high quality care. We will develop an integrated and collaborative approach to quality governance and assurance across the Frimley Health and Care system that minimises duplication, reduces variation and delivers tangible improvements for local people and staff satisfaction. Our strategic approach to assurance and improvement includes the following:

• We will develop further our Frimley ICS Quality and Performance Committee to provide strategic leadership and oversight for quality across the ICS
• We will implement a shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and 3rd sector
• We will implement the quality governance and assurance mechanisms across the system that reduces duplication and focuses on improvement
• We will further develop quality resource and information flows across the system to reduce duplication and release capacity
• We will implement system approaches to quality through developing a single Frimley system quality account and agreed system priorities, developing an system-wide serious incident review and learning process where incidents cross organisations. There will specific actions and learning from the Gosport Independent panel and Government response that will be implemented across the ICS
• We will champion and integrate the concept of the ‘persons time’ as the most important currency in health and social care
• We will use existing /develop metrics to understand the impact of workforce on quality

There are ten key areas where there needs to be a system wide approach to make a difference in patient safety, effectiveness and experience. A system wide approach was established in 2018-19 and in 2019-20 there will be further developments. The following areas will be monitored through the agreed quality approach and process:

• Reducing Gram-Negative Blood stream Infections
• Sepsis
• Persons Time
• Work with care homes on quality initiatives in partnership with the care homes work stream
• Mortality Review
• Learning Disabilities Mortality Review Programme (LeDeR)
• People being cared for in the right place at the right time
• Falls
• Pressure Ulcers
• Safeguarding
Improving Quality

**Description**

**Reducing Gram-Negative Blood stream Infections (BSIs)**

The Secretary of State for Health has launched an important ambition to reduce Gram-negative Blood Stream Infections by 50% by 2021. Evidence shows that these infections may have contributed to approximately 5,500 NHS patient deaths in 2015. Escherichia coli (E. coli) BSIs, represent 55% of all Gram-negative BSIs. E. coli BSIs have increased by a fifth in the last five years and preventing BSIs should have a major impact on reducing the need to prescribe antimicrobials, which is a key way of reducing the rise in antibiotic resistance. The aim in 2019-20 is to further implement a system wide infection prevention and control action plan which will include a specific work stream on how to reduce the numbers of Gram-Negative BSIs. This action plan needs to deliver the reduction that is required to reduce the number of people contracting these infections. This needs ownership from all levels of the organisations in acute, community and primary care. Monitoring will be at an ICS level. Areas already for continuation in year is to review of all cases to identify any themes or trends, reduction of urinary tract infections (as this has been identified as the most common source) through a hydration campaign to the local population. We will implement the agreed catheter passport across the ICS and develop an ICS project on reducing the number of people who have catheters inserted. We will continue to learn from well performing organisations and participate in the National Collaborative.

**Sepsis**

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. There needs to be a systematic approach towards the prompt identification and appropriate treatment of this life-threatening condition. Across the system there are opportunities to improve the identification of the deteriorating patient, in primary care, community care including care homes, urgent and emergency care and inpatients. The aim for 2019-20 is for the ICS Quality and Performance Committee to monitor the data, identify areas for improvement and monitor new approaches for their impact for example implementation and monitoring of NEWS 2 (National Early Warning Score) care homes and the Suspicion of Sepsis (SOS) Insights Dashboard.

**Person’s Time**

Time is the most important currency in health and social care. It manifests itself in persons waiting, duplication, health and social care staff running around looking for things and needless harm being caused. Person time as a key metric of performance and quality and is best measured from the perspective of the person. The aim for 2019-20 from an ICS perspective is to implement the concept of persons time and to deliver services from a perspective of the person. Working with other work streams to support them to ensure the person is at the centre of planning and pathways valuing them and their time as being an important component of care, improving the patient experience whilst reducing waste for example medications are ready for when a patient is able to be discharged and using Skype for out patient appointments. Examples of good practice and benefits to be shared with ICS work streams and mechanisms for ensuring that this is embedded in the heart of service design such as incorporating into the QI assessments.

**Care home Quality**

As part of the Gosport action plan care homes in some cases are isolated organisations and the ICS will work with them on education and training for example implementation of NEWS 2. To be provided with regular updates from the Care Homes Quality group on different quality initiative for example ensuring the quality of care provided to residents through primary and community care.
Improving Quality

**Description**

**Mortality Reviews**

Following the findings of the Care Quality Commission report ‘Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England’ (Dec 2016), the National Quality and Performance Committee (NQB) published the first edition of National Guidance on Learning from Deaths for Trusts (March 2017). The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process. Our aim for 2019-20 is to continue co-operation and co-ordination across all providers so that there can be shared learning from the reviews. There is also continuing oversight of improvement actions emanating from the mortality reviews. Both Frimley Health NHS Foundation Trust (FHFT) and Berkshire Healthcare NHS Foundation Trust (BHFT) have developed and implemented Learning from Death policies which align with the framework set out in the national guidance. These include defined processes for retrospective case record reviews, criteria for deeper reviews using Structured Judgement Review Model methodology, and identification of (and reporting on) cases where death was potentially avoidable. FHFT will be adopting the Medical Examiner Model. These reviews feed into Trust governance processes, with formally established review groups operating under committee and board oversight. This will continue in the forthcoming year. All organisations who hold mortality reviews also participate in a wider ICS Mortality Review Group, into which learning from provider mortality reviews is fed and cross-organisational improvement actions and learning are identified and promoted. These cross-organisational groups can facilitate multi-agency input into provider mortality reviews where required.

**Learning Disabilities Mortality Review Programme (LeDeR)**

These reviews focus specifically on reviewing the deaths of people with learning disabilities., through mortality case review. There is active participation in the LeDeR programme with organisations both in social and health care providing reviewers and representation on the LeDeR Reviewers and Steering Groups. Our aim for 2019-20 for LeDeR is to support health and social care professionals, to clarify causes of death and excess premature mortality for people with learning disabilities; identify variation and best practice; and identify and implement key areas for improvement. The aim of the programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population.

**People being cared for in the right place at the right time**

There are a number of work streams across the system that are working on the patient journey, particularly for those individuals who are frail. This could be through admission avoidance, or embedding and strengthening discharge processes across the whole system. For the ICS Quality and Performance Committee to understand any patient safety issues through monitoring complaints, concerns and incidents that are related to patient flow in and out of hospital. To escalate quality issues to the ICS A&E Board via the Quality dashboard. Develop a collective agreement of a zero tolerance approach to children and young people with mental health issues being cared for in an unsuitable and inappropriate therapeutic environment. To continue the joint working on Improving services for people with mental health needs who present to A&E (CQUIN 2017-19).

**Falls**

From January-December 2018 there were 3,345 falls reported as incidents across the ICS. In 2019-20 the ICS Quality and Performance Committee will develop a programme of work to share learning and monitor improvement following the NHSI falls improvement work in FHFT and BHFT Quality Improvement programme. The ICS will also identify the care homes with the highest numbers of falls and facilitate a falls intervention programme.
Improving Quality

Description
Pressure Ulcers
Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. In 2019-20 there will be an ICS approach in implementation of the Pressure ulcers: revised definition and measurement summary and recommendations. This will provide a consistent approach for staff. To work across the ICS on ways to reduce the number of pressure ulcers by learning from each other and to develop initiatives for celebrating successes e.g. services with no pressure ulcers identified for 100 days.

Safeguarding
In 2019-20 we will continue safeguarding being integral to all aspects of care delivery. We will support the continuous improvement of early detection of safeguarding risks to service users, system wide partnership working and appropriate onward referrals. We will develop an integrated and collaborative approach to safeguarding governance and assurance across the Frimley Health and Care system that minimises duplication, reduces variation and delivers system wide learning from serious case reviews, partnership reviews, domestic homicide reviews and mental health homicide reviews. We will develop our already established strategic group to include safeguarding leads from providers and CCGs across the ICS; this will provide leadership and strategic direction and also share and extend local projects to apply to whole ICS area. This may include for example, safe sleeping and carer initiatives.

We will also:
• Develop safeguarding resource and information flow across the ICS and reduce duplication across the Child and Adult agendas
• Provide safeguarding leadership during joint Ofsted/CQC safeguarding inspections and SEND inspections
• Develop the current Thames Valley ambulance forum to include all safeguarding leads within the ICS to avoid duplication and strive for continuous improvement
• Work with the local authorities and our Police partners to develop new safeguarding boards which synergise with the whole ICS partnership, ensuring the CCGs in each area hold equal responsibility for implementation in line with Working Together 2018
• We will work with the safeguarding adult boards to ensure integrated working across the ICS and standard practice when considering cases for safeguarding adult reviews
• Safeguarding teams will continue to link with the LeDeR and CDOP reviews to ensure a reduction of duplication and safeguarding oversight
• We will agree and implement new policies for the ICS outlining duties placed on health organisations under the new Liberty Protection Standards due to be implemented late 2019 and replacing the current Deprivation of Liberty (DOLs) system. Following the Gosport report and actions that the ICS has robust processes in place for Mental Capacity
• We will work to develop an ICS LAC designated professionals network work on priority work streams from the South East to feed into the national LAC framework
• To work across the system on youth violence initiatives
Improving Quality

Description
There is a significant amount of work being undertaken in the ICS Mental Health programme and the Quality Board will have a clear line of sight on both Out of Area Placements (OAPs) and Safety Planning:

Out of Area Placements (OAP)
A person with assessed acute mental health needs who requires acute adult mental health in patient care, is admitted to a unit that does not form part of their usual network of services is considered to be placed in an OAP. The negative impact for service users, their families and professionals involved in the care of the service user is significant. The impact includes: Being away from their families and friends (their support networks when they need them the most); increased length of stays; and poorer outcomes, including increased risk of suicide. The national aspiration is to eliminate OAPs by 2021 and this will improve care, experience and efficiency.

Zero Suicide Ambition – safety planning
Over the coming year the Zero Suicide Ambition will focus on safety planning and specifically on effective plans to reduce self-harm and suicide within mental health inpatient services and Crisis Response and Home Treatment Teams (CRHTT). Nationally, suicide levels on mental health wards has plateaued over the last 8 years and it is known from the confidential inquiry that the most vulnerable period for patients is in first few days post discharge. Improved safety planning will be personalised, of high quality and developed through robust and meaningful conversations with patients and their families to ensure that safety planning is seen as a therapeutic intervention that assists patients to keep themselves safe.

How will Quality look by the end March 2020?
Local Population
People will be cared for at the right time in the right place by a skilled workforce. Children, young people and their families will be able to receive care in the most appropriate setting in a more timely way. People will have received self care and prevention messages for example so that they do not suffer from blood stream Infections and if they do have an infection then they will be treated quickly for an improved recovery. People will be cared for in safe and good quality environments. As ‘Persons Time’ is beginning to be implemented people will experience services delivered in a way that values their time, which results in easier journeys through services in the identified areas for improvement. Reassure the local population on the actions and learning taken on serious incidents and the Gosport inquiry through organisation Boards. The ICS will ensure that equality and diversity impact assessments are undertaken on the work that it carries out with oversight through the ICS Quality and Performance Committee.

Staff
There will be a maturing Quality governance process in place across the ICS which will monitor quality indicators and patient experience using sources from the quality dashboard, learning from mortality reviews, LeDeR, safeguarding, complaints Gosport Independent panel and Government response and incidents. This will reduce bureaucracy and support staff in a culture of learning from incidents and complaints and a culture of improvement. The culture of improvement will be part of the Improvement Network (IN) which will offer guidance and mentoring in Quality Improvement (QI), cascade the development of system leadership and QI skills, tools, mind sets and behaviour across the ICS, connect people working on improvement across the system and establish and grow a library/knowledge bank of quality improvement best practice (see Section 7 under System and Leadership Development).
Improving Quality

Outcomes and Benefits

Quality will be better understood and managed at a system level, with a maturing quality dashboard that provides analysis at a system level and this will facilitate improvements through the following:

• To promote self care messages to the public to reduce the number of Gram negative blood stream infections. Reduction in the number of blood stream infections and thereby reducing the need for antibiotics, reducing the opportunity for infections to develop a resistance to them
• Sepsis – Earlier identification will lead to quicker appropriate treatment for the deteriorating person and improve their outcome for recovery. An increase in the earlier detection of sepsis and NEWS2 implemented in Care Homes
• Mortality reviews, LeDeR Serious incidents and safeguarding – These processes can assure the public and staff that actions and learning are being undertaken. Organisations will share in a system-wide commitment to ensure that local and national recommendations are enacted into service delivery from LeDeR
• Improved quality in care homes will reduce unplanned admissions, and an educated workforce
• Persons Time – to deliver services in a way that values the individual users time in the identified areas for improvement
• To reduce the harm suffered by people while in health and social care settings from falls and pressure ulcers
• Children and Young People will be treated and begin their recovery sooner and this will be measured through the number of CTR carried out for children in crisis in the wrong environment. Reduction in number of A&E attendances

Key Risks and Mitigation

• No agreed strategic approach on the future processes to monitor and assure on quality areas
• A lack of joint working on the ten key areas. These risks will be mitigated via the ICS Board which will hold the Quality and Performance Committee to account for delivery of quality across the ICS in the key areas
• No reduction in the Blood stream infections. This risk will be mitigated through the Infection prevention and control action plan and will be monitored by NHS England
• No reduction in the number of falls or pressure ulcers. This will be mitigated by quarterly monitoring and improvement plan if no reduction
• No identified leads for the programmes of work. Quality and Performance Committee will identify leads in April 2019
• Not implementing key actions from the Gosport independent panel and Government response. This will be monitored by NHSE and NHSI
# Improving Quality

## Milestones

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<tr>
<th>Q1</th>
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<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>• Quality Operational Group established and identified leads</td>
<td>• Review and refinement of the quality dashboard completed</td>
<td>• Shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and 3rd sector developed</td>
<td>• Benefits of the quality dashboard evaluated</td>
</tr>
<tr>
<td>• Implementation completed of the quality governance assurance and data flow mechanisms</td>
<td>• Review completed of the Quality and Equality and Diversity Impact Assessments</td>
<td>• A single Frimley system quality account developed</td>
<td>• Shared definition, vision and understanding of quality agreed</td>
</tr>
<tr>
<td>• Scope of human factors training to support system wide improvement in learning from incidents completed</td>
<td>• System-wide serious incident review process implemented</td>
<td>• Human factors training across ICS implemented</td>
<td>• Single Frimley system quality account signed off</td>
</tr>
<tr>
<td>• ICS action plan agreed for the Gosport review</td>
<td>• Quality impact assessment on workforce challenges completed</td>
<td>• System-wide serious incident review process embedded</td>
<td>• ICS action plan for the Gosport review implemented</td>
</tr>
<tr>
<td>• Work with the other workstreams on the concept of ‘person’s time’ mapped and embedded within the service redesign processes</td>
<td>• Shared definition, vision and understanding of quality agreed</td>
<td>• Implementation of actions from the Quality impact assessment.</td>
<td>• Audit of learning from person time activity completed</td>
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<th>Q1</th>
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<tbody>
<tr>
<td>• Sepsis data reviewed and areas for improvement identified. Sepsis dashboard scoped for implementation</td>
<td>• Catheter project developed to reduce the number of long term catheter insertion by 20% by 2020. Audit catheter numbers for baseline</td>
<td>• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions</td>
<td>• KPI data trajectory reviewed for reduction of Gram negative BSIs.</td>
</tr>
<tr>
<td>• System-wide serious incident review process implemented</td>
<td>• Catheter project developed to reduce the number of long term catheter insertion by 20% by 2020. Audit catheter numbers for baseline</td>
<td>• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions</td>
<td>• Reduction in the number of catheters</td>
</tr>
<tr>
<td>• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions</td>
<td>• System-wide serious incident review process embedded</td>
<td>• System-wide serious incident review process embedded</td>
<td>• Suspicion of Sepsis Insights dashboard implemented</td>
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## Improving Quality

### Milestones

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</table>
| • Plan of care home quality work presented to ICS Quality and Performance Committee. Annual review for 2018-19 completed  
• Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.  
• Learning and improvements on falls from the work undertaken by FH and BHFT shared and ICS actions to reduce the number of falls identified | • Quarterly review of progress against the plan completed  
• Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. | • Improvement data shows improve outcomes for patients. Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions.  
• Quarterly review of progress against the plan completed and for ICS Quality and performance committee. Any quality issues identified particularly around support from Primary Care  
• Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. | • Quarterly review of progress against the plan completed (and taken where?) Any quality issues identified particularly around support from Primary Care  
• Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.  
• Number of falls across the system reduced by 10% |

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| • Baseline data reviewed from 2018-19 CQUIN on improving services for people with mental health needs by identifying a new cohort of patients. Milestones as per the CQUIN  
• Baseline data reviewed on the number of children and young people being cared for in an unsuitable environment  
• Baseline data reviewed for all organisations on the number of days where there has been no pressure ulcers developed. Public messaging for prevention developed and circulated | • Quarterly report presented to Quality and Performance Committee on progress and improvement  
• Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee | • Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement  
• Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee | • Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement  
• Reduction achieved in number of incidents reported from the baseline in Q1  
• Celebration event for those services who have improved or had no pressure ulcers over the year. Public messaging evaluated  
• Reduction achieved from the baseline on number of pressure ulcers across the ICS |
## Improving Quality

### Milestones

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<th>Q4</th>
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<tbody>
<tr>
<td>• Consistent approach for definition measurement and reporting Baseline data established. % reduction agreed across the ICS</td>
<td>• Ambulance forums established</td>
<td>• Safeguarding resource and information flow across the ICS developed</td>
<td>• Annual report on activity completed</td>
</tr>
<tr>
<td>• To develop a plan on how to work across the system on youth violence initiatives</td>
<td>• Standard practice across the ICS when considering safeguarding adult reviews aligned</td>
<td>• LAC designated professionals network extended to Hampshire and Surrey professionals. Priority workstreams from South East feed into the national LAC framework</td>
<td>• Audit completed on the practice across the ICS</td>
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<tr>
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<td>• Audit completed on the robustness of systems for determining mental capacity</td>
<td></td>
<td>• Evaluation report completed on plan Monitor the implementation of the plan and evaluate whether this has been successful</td>
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<tr>
<td></td>
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<td>• Audit completed on the robustness of systems for determining mental capacity</td>
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</table>
Frimley Health and Care Integrated Care System (ICS) is submitting a balanced plan for 2019-20, with a system control total of a surplus of £26.9m. The system is a self-governing system and the delivery of the control total is reliant on the delivery of the consolidated financial position of the six NHS partners within the ICS.

The individual plans have been developed at organisation level in full view of all the system partners as it is clear that 2019-20 will be extremely challenging, balancing organisational sustainability and supporting longer term transformation to move the system to recurrent balance and reduce inequalities.

The system plan contains the use of additional funding that may be available to the system but still has a level of unmitigated risk.

**Detail**

System leaders have been kept fully sighted regarding the system wide financial position with a gap of c.£31m identified across the NHS partners when plans were submitted in February 2019, with provider income requirements in excess of commissioner affordability. Significant work has been undertaken across the system to close the gap to £4.6m, with organisations continuing to hold a level of contingency and reserves within their plans which may be used to close the gap and achieve a balanced plan.

Progress has been made to align contracts within the system and these contract figures are set within the context of the overall financial framework. As at 25th March 2019, risks remain across contracts outside the system in excess of £6.1m.

The system commits to delivering expenditure plans agreed and to develop the culture, systems, and processes to manage in year risks across the system. During 2018-19, the ICS had been working on the introduction of payment reforms in 2019-20 and have been assisted with this by KPMG. The system recognises that the current payment mechanism does not correlate to the cost of the health care being provided. We aim to move to a more cost based payment mechanism away from traditional Payment by Results (PbR). The 2019-20 planning process has helped identify areas that can be strengthened to support this process.
Financial Sustainability: Overview

**Context**
The Frimley Health and Care ICS has a combined NHS funding allocation of almost £1.1bn plus additional out of system funding of £0.3bn, taking total NHS Health Care Funding to approaching £1.4bn. In addition to this, our two County Councils and three Unitary Authorities have combined funding allocated to the system of c.£0.3bn.

For 2018-19, the NHS health care system is planning to deliver its control total, although pressures across the system have been mitigated largely from non recurrent funding.

Moving into 2019-20, the system will work to deliver a shared control total of £26.9m. In order to meet this, efficiencies totalling £64.6m will need to be delivered. This includes £10.3m of system wide stretch targets to reduce the cost of growth and an agreement to hold lower levels of contingencies and reserves.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2018-19 Control Total</th>
<th>2019-20 Planned Control Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Berkshire CCG</td>
<td>-0.8</td>
<td>0.0</td>
</tr>
<tr>
<td>NHS North East Hampshire and Farnham CCG</td>
<td>-0.3</td>
<td>0.0</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Frimley Health NHS Foundation Trust</td>
<td>33.3</td>
<td>26.2</td>
</tr>
<tr>
<td>Berkshire Healthcare NHS Foundation Trust (40%)</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Surrey and Borders Partnership NHS Foundation Trust (22%)</td>
<td>0.9</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total Frimley Integrated Care System (NHS)</strong></td>
<td><strong>34.1</strong></td>
<td><strong>26.9</strong></td>
</tr>
</tbody>
</table>
Underlying Financial Position and Efficiency plans

Underlying financial position
The system will end the financial year as planned but this has been reliant on the use of non recurrent contingencies and reserves plus the final year of the merger deficit support funding of £13.8m.

Moving into 2019-20 the system has agreed an underlying deficit of c.£35m to a break even budget. The system will benefit from increased allocations of £55m and increased external funding of £15m (primarily contract income from commissioners outside the ICS). Cost inflation, more demand on services, and investments to meet national standards results in the underlying deficit increasing significantly before efficiencies. The system has then identified £64.6m of savings in order to meet its national control total, recurrent delivery of which will see the underlying deficit reduce by the end of 2019-20.

Efficiency plans

<table>
<thead>
<tr>
<th>Expenditure efficiency plans within ICS</th>
<th>%</th>
<th>Total Efficiency plan within ICS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Berkshire CCG</td>
<td>8.9</td>
<td>2.8%</td>
<td>12.8</td>
</tr>
<tr>
<td>NHS North East Hampshire and Farnham CCG</td>
<td>5.0</td>
<td>3.0%</td>
<td>9.0</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>1.5</td>
<td>2.0%</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total CCGs</strong></td>
<td>15.4</td>
<td>2.8%</td>
<td>24.3</td>
</tr>
<tr>
<td>Frimley Health NHS Foundation Trust</td>
<td>25.4</td>
<td>3.8%</td>
<td>25.4</td>
</tr>
<tr>
<td>Berkshire Healthcare NHS Foundation Trust (40%)</td>
<td>3.1</td>
<td>3.0%</td>
<td>3.1</td>
</tr>
<tr>
<td>Surrey and Borders Partnership NHS Foundation Trust (22%)</td>
<td>1.5</td>
<td>3.4%</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total Providers</strong></td>
<td>30.0</td>
<td>3.6%</td>
<td>30.0</td>
</tr>
<tr>
<td>System Stretch</td>
<td>10.3</td>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Total Frimley Integrated Care System (NHS)</strong></td>
<td>55.7</td>
<td>3.1%</td>
<td>64.6</td>
</tr>
</tbody>
</table>

In closing the 2019/20 plans across the system stretch savings targets of £10.3m were agreed. These targets will be collectively owned and delivered by the system.

These include: A systematic review of all investments; Outpatient transformation; review of activity undertaken within the system and opportunities to refocus activity on high value adding activity; and transformation of back office services to reduce administrative cost and protect front line services.

Frimley Health has set an internal CIP target of £30.5m to deliver this. Berkshire Healthcare and Surrey & Borders figures reflect the ICS’s share of their overall savings plan.
For 2019-20 we will continue to operate under a shared system control total to deliver improved system outcomes. Under the full system control total the financial performance of the six NHS organisations will be managed first on collective financial performance, then their individual performance.

In order to support the delivery of a system control total, we will work collaboratively to manage pressures across the system, ensuring that remedial actions are identified that deliver improvements for the ‘Tax-payers’ pound and not just moving pressures between organisations. These risks will be monitored monthly by the ICS Finance Reference Group where Chief Finance Officers/ Finance Directors of all NHS partners and Heads of Finance from local authority partners are in attendance.

The system has been working with the national payment teams and KPMG to develop these options for implementation in 2019-20. Any changes will be made transparently and in a way which avoids unintended consequences.

### Financial Sustainability: Reforming system payment mechanisms

**2018/19**

- **Current payment approaches**
  - Mix of payment approaches, e.g. PbR for acute, block for community services, some full block contracts – not aligned to care models
  - Limited cost data means payment unlikely to reflect efficient cost of services
  - Some systems moving towards blended payment, but with limitations
    - Any variable elements or risk shares are ‘simplistic’
    - Generally focused on acute

**2019/20**

- **Interim payment approaches**
  - Move towards a more developed form of blended payment across the whole system
  - Fixed elements set based on improved cost data and more accurate activity forecasts aligned to plans
  - Variable elements set based on understanding of costs of activity above/below plan
  - Greater alignment of payment models across settings and providers
  - Agreed plans for how resources flow around the system, aligned to care models

**Long-term aspirations for payments**

- Based on near real-time, patient-level cost, activity and outcomes data
- Resources follow the patient and therefore closely align to the model of care
- All services are funded at the level of efficient cost
- Large proportion of payment is linked to patient / population outcomes
- Long-term financial planning by system partners enables proactive investment in services
- Transparent sharing of activity, costing and finance data supports efficient allocation of resources
Financial Sustainability: Reforming system payment mechanisms

Payment reform can help because it can:

- **Improve transparency** on financial performance within the ICS
- **Improve collaboration** between providers and providers and CCGs
- Improve overall **system performance**

...because:

- It is an **incremental method** to help providers take on risk and manage care better.
- It can help get the **care priorities aligned** with the SYFV through the reimbursement of care based on quality measures

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**What our payment reform can look like moving towards an intelligent fixed payment:**

- **Historical payments**
  - Adjusted for:
    - Economic inflation
    - Changes in population mix
    - Changes in activity
    - Changes in care delivery model (e.g., IoT services)
    - Impact of shifts in care environment (e.g., other providers stop providing certain services)
    - Changes in NHSE QIP/CIP & Standard tariff rates
    - ...
    - Potentially including some variable elements (e.g., expensive medicine or import of patients from outside of the ICS)

- **Intelligent fixed payment (99%)**
- **Quality based payment (1%)**
- **Risk & gain share**

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

Context
Frimley Health and Care ICS has made good progress on managing activity demand across the acute sector which in turn enables funding to be diverted to support the provision of care for our community closer to home. A&E attendances, non-elective admissions and elective admissions are used by the system to monitor changes in the flow of patients.

The investment included in the system financial plans focus on delivery of proactive care with the full roll out of Integrated Care Decision Making across the system. These build upon successes in North East Hampshire and Farnham and Surrey Heath CCGs where emergency admissions have remained under national levels. A systematic review of 6 specialities, utilising the NHS RightCare methodology will focus on maximising utilisation of acute capacity, reducing unnecessary appointments in an acute setting, with a focus on community and primary care based delivery. This will build on improvements already seen and result in stepped changes in the level of elective demand experienced by the system.

Detail
For 2019-20 activity plans have been fully aligned within the ICS with a single set of activity assumptions agreed for acute activity within Frimley Health NHS Foundation Trust. A selection of headline figures, before the impact of transformation savings, are presented below. This represents overall ICS acute activity at all providers.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendances</td>
<td>2.2%</td>
<td>1.8%</td>
<td>0.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Non-Elective admissions (same day &amp; overnight)</td>
<td>7.1%</td>
<td>-1.7%</td>
<td>-0.7%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Elective Admissions (same day &amp; overnight)</td>
<td>5.7%</td>
<td>-1.4%</td>
<td>0.6%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>
**Aim**

Our Communications and Engagement Strategy is to work with our stakeholders and local people to ensure we communicate and engage on the things that matter most. We want to promote how we are transforming seamless local health and care services to local people, their families and carers. We will bring together all key stakeholders, including GPs, colleagues in local authorities and representatives of voluntary and community organisations and the local community, to ensure we are joined up in the way we engage, from communicating key messages through to co-design and co-production.

**Description**

Working together we have to take a proactive and inclusive approach to engagement to ensure that patients, public, staff and stakeholders are fully informed, involved and partners in the development of services from the earliest possible moment.

Our Communications and Engagement Strategy is to have:

- Clear and visible senior commitment to high quality meaningful communications and engagement
- High quality communications and engagement to support the delivery of our priorities across the system
- Consistent messages to enable effective relationships and build communications and engagement to take place on the things that matter most
- To put people first, creating open and honest debate that will support strong partnership working

Building on our existing engagement, to support our strategy we bring together all key stakeholders, including GPs, colleagues in local authorities and representatives of voluntary and community organisations and the local community, to ensure we are joined up in the way we engage, from communicating key messages through to co-design and co-production. The Frimley Health and Care Health and Wellbeing Alliance Board represents the five Health and Wellbeing Boards covered by the Frimley system footprint. The aim of the group is to bring added value to the ICS and to ensure communication and engagement is not only locally valid, but consistent and coherent across the system, providing a vital link between the ICS and the local communities the members serve.

We have a Communications and Engagement Network represented by the communications and engagement leads from the organisations involved in the Frimley system, collectively supporting the day to day deliverables across each priority work stream and the broader system. The Communications and Engagement Strategy has been developed by senior leaders and communications and engagement leads across the footprint and focusses on six key areas; engagement governance, identity, profile and promotion, stakeholder management and developing the right support and tools. The Communications and Engagement Strategy is underpinned by the operational work stream communications and engagement plans that support the development and delivery of local service transformation.
Communication and Engagement

Deliverables
During 2019-20 we will deliver the following:

- We will establish a Citizens’ Panel, which will be a representative, consultative body of local residents. Participants are recruited through random sampling of the electoral roll or postcode address file or by other means to ensure recruitment of socially excluded and hard to reach groups. The aim of the panel will be to identify local priorities and to consult service users and non-users on specific issues, which can be linked to population based data.
- Frimley Health and Care is one of five systems that have been selected to take part in the national Building Healthy Partnerships programme that builds relationships between the voluntary, community and social enterprise sector and STPs/ICS that deliver improvements to health and care for local people. It is designed to help systems to better engage and involve patients and the voluntary, community and social enterprise sector in working around issues specific to our system. Our focus will be prevention and self-care, focused on hard to reach sections of our community and digital solutions.
- To hold a series of pop up events across our geography, developing a shared story of our new models of integrated working that we can further promote via social media, website and possible film.
- Further developing of the ICS story and identity through our social media and on-line presence, ensuring consistent messages based on delivery and real change, providing clarity for staff, partners, patients and their families and the public.
- Using the website, connect effectively and consistently with our communities providing opportunities for engagement and a place to feedback about public involvement in shaping and delivering our shared priorities, developing our engagement capacity through community ambassadors and community forum across the system.
- Develop an on-line tool for the Leadership Academy and workforce, supporting the ‘good place to work’ agenda.
- Further develop our connectivity with our voluntary sector, Healthwatch, and local community, resident and patient engagement groups. Develop shared principles.
- Maximising opportunities to share our messages locally and nationally.
- We will be proactive in our communications with key influencers and opinion formers, such as the media, MPs and others.

How will services look by the end March 2020?
The benefits of working in an integrated way means that we can co-ordinate engagement, co-design and communication to ensure that they are consistent, accessible and making the best use of capacity and resources. We will know we are getting it right when:

- Members of the public know how the ICS will impact on the health and care that they (or their families) receive and can access information and support to look after their own health and people they care for.
- Our stakeholders support, and are aligned to, our priorities.
- Staff understand their roles in delivering our ambition and can explain what the ICS is doing, quoting examples of how we are making a difference.
- Local people will be working with us to describe how best to provide self-care and prevention tools and support, and we will be developing those tools using a co-design approach.
Communication and Engagement

Outcomes and Benefits

Patient experience
- Early involvement and co-design of patient, resident and local community views and experiences to shape services that we plan, commission and deliver
- Consistent opportunities for meaningful engagement with all partners across the footprint
- Identification and targeted work with seldom heard groups including those groups who are hard to reach such as those with protected characteristics, but also groups such as commuters, families, young people.
- Improved patient experience and satisfaction of individuals receiving treatment and assessment
- Good communication delivered through a range of engagement opportunities so support the range of abilities, disabilities and opportunities across the system
- Equity of access for all patients and local service delivery
- Improved understanding and accessibility of the system delivery and transformational change and the impact it has on local people

Service Integration
- Shared messages to support joined up working across the ICS
- Increased understanding of health and care as one system without traditional organisational boundaries

Outcomes and Benefits

- Good understanding of how people can be involved in the re-design of local services
- Spreading good practice across the footprint and lessons learnt
- Building understanding of new models of care
- Better services, designed by people who use them
- Improved understanding of how to access and make the most of local services and local service transformation
- Better information to support people to look after their health and wellbeing

System Sustainability
- A pro-active approach to communications and engagement will support system-wide understanding, implementation and evaluation
- Helping people maintain independence and manage their own health and care through communication campaigns and messaging
- Driving forward real examples and opportunities across the system to support the system being a ‘good place to work’ in line with recruitment and retention of our workforce

Key Risks and Mitigation

- The key risks are limited available communication and engagement capacity. In order to mitigate these risks, a NHS England funding bid has been submitted and further work to review how we can co-ordinate roles across the system needs to be undertaken.
Our ICS continues to develop through consolidating partnership working, supporting relationship building, operating a system control total and making partnership based local investment decisions to support our change programme. Our local organisations have agreed a delegated responsibility structure to support our ICS Board role in system maturity and development. We aim to reduce duplication, so that in the system we do things only once. We are developing stronger assurance processes within the system to support a changed relationship with regulators, while reducing the overall administration. The system will focus on enabling transformational change whilst strengthening self assurance.

The ICS enabling structures include:

- At ICS Board there will be regular review of our strategic priorities, risks and dashboards, taking corrective action to ensure we maintain focus on and achievement of outcomes and benefits, and move towards a more sustainable system.
- We are maturing in Self Assurance and have created a Lay/Non-Executive Director assurance group to provide a clear line of sight across the ICS for independent scrutiny of processes, deployment of funds and activities, mindful of risk and of real or perceived conflict of interest.
- We recognise there are significant risks to delivery including daily operational pressure and limited capacity across the system. By working together we will minimise risk by reducing duplication, consolidating and aligning effort and resource and looking to agree joint incentives to bring greatest benefit for the least spend.
- The Programme Delivery Board brings together senior executive level officers responsible for delivery and assurance across all aspects of our plan.
- Our system wide Finance Reference Group reviews progress against our financial plans at system and organisational level. They also monitor investment against achievement of priorities.
- A newly established Quality and Performance Committee drives improvement and monitors performance against quality measures at a system level. It escalates unmitigated risk to the ICS Board.
- Our Health and Well-being Alliance Board allows our elected members to advise and shape our communications and engagement, feed back on priorities and help with alignment across partners.

**ICS Mechanisms and Enabling Structures**

Our ICS operates through a range of mechanisms, including a single ICS leader, a system wide **ICS Board** with delegated authority, this system operating plan, a system-level accountability framework, a system control total for health and a blend of system and local governance to meet all required standards.
System Governance

ICS Board

Finance
- System Control Total
- Long term financial model and cost drivers
- Demand and capacity modelling
- CIPP/ QIPP
- Transition to system-cost based business cases

Quality & Performance
- Quality
- Constitutional standards and their impact on quality
- Local performance metrics (based on quality priorities)
- Risk-based reviews through operational horizon scanning
- Quality and performance dashboard, system and national

Clinical
- Translation of population health information into health and care strategy
- Priorities for clinical change programmes
- Unblocking – final clinical view

Programme Delivery
- Five Year Forward View
- Transformation programmes
- System Operating Plan
- Alignment with Local Digital Roadmap

Health & Wellbeing Alliance
- Involvement of residents
- 360° feedback for the ICS
- Strategic horizon scanning

Workforce/Leadership
- System workforce strategy
- Alignment with HEE regional/national
- Local HR alignment to aid delivery
- Leadership and Improvement Academy

Lay Assurance Group
### Risks and Assurance

**The ICS Board has identified the following areas of risk at a system level:**

- Financial sustainability in the short to medium term
- Building a workforce fit for the future
- Having the right information and evidence to inform decision making for our population
- Working effectively with our national partners and neighbouring systems
- Maintaining positive system relationships through times of change and challenge
- Having capability and capacity to deliver and maintain change
- To work with and engage community in change

The following high level categories of programme risks have been identified and are described together with mitigating actions in the table below. We will manage risk through the ICS Board and its key sub-committees for assurance: Quality and Performance Committee, Programme Delivery Board and Financial Reference Group, in addition to managing at the workstream level.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability of primary care to transform at pace and scale required to achieve sustainability</td>
<td>Support GP network development and support them to deliver workforce strategy and workforce plan for General Practice Forward View</td>
</tr>
<tr>
<td>A delay in international GP recruitment with fewer GPs recruited than anticipated has meant we have insufficient GPs in the pipeline to meet demand</td>
<td>MDT Working and new models of care - expanding our primary care skill base through multidisciplinary working will help to manage the demand. In addition to GP recruitment plans are in place to support the retention of newly qualified GPs and experienced GPs</td>
</tr>
<tr>
<td>Capacity of clinicians within the system to engage in ICS programmes</td>
<td>Continue to further system wide ownership of ICS priorities, engagement plan and commitment to achieve change. Provide backfill support for clinician time</td>
</tr>
<tr>
<td>Workforce capacity, recruitment and retention in health and social care is not sufficient to deliver required level of service transformation</td>
<td>Managed through the Workforce Strategy. Hold joint recruitment events to attract people to work in the health and care sector. Develop a communications approach that emphasises the advantages of working in the health and care sector to address negative perceptions. Strengthen workforce leadership at ICS Board level</td>
</tr>
<tr>
<td>Increase in demand for services with insufficient capacity within the system to cope resulting in unsafe care</td>
<td>Review of activity levels and system pressures to ensure early intervention is carried out to deliver safe care and recover standards. Understand drivers of demand, including prevention and cost-based approach to planning</td>
</tr>
</tbody>
</table>

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*RISKS AND ASSURANCE*
## Risks and Assurance

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing and transforming a workforce we do not ‘own’</td>
<td>Working closely with the care providers to develop shared training packages, support workforce and address issues / barriers to system wide working i.e. contracts, terms and conditions, rates of pay etc.</td>
</tr>
<tr>
<td>There are emerging competency gaps and increasing problems with recruitment and retention in the domiciliary and care home markets (with 47% of care homes rated inadequate by CQC)</td>
<td>Developing initiatives such as Coach to Lead with the aim to develop care home managers and senior leaders across the ICS area with the skills to use a coaching style of leadership. Hydration was flagged as a key issue in CQC inspections therefore a joint train the trainer approach. Good Hydration in Care Homes commenced in November 2018. The aim is to train trainers to roll out the Good Hydration Project to all Care Homes across the geography.</td>
</tr>
<tr>
<td>Massive and complex workforce transformation required to deliver today’s and tomorrow’s MH services</td>
<td>Plans are in place to develop a system wide mental health workforce plan. A workforce lead is to be recruited to further our knowledge of the current workforce across all the stakeholders in the ICS and develop a strategy which will include training needs and new roles across the system.</td>
</tr>
<tr>
<td>Limited communication/ stakeholder engagement across the ICS</td>
<td>The Health and Wellbeing Alliance Board and the Communications and Engagement Network have a role to ensure that all have a voice and actively influence and participate in the delivery of the ICS. Wider plans to touch all staff and wider public through ‘Canterbury NZ’ like programme</td>
</tr>
<tr>
<td>Limited engagement with patients and the public over our transformation plans</td>
<td>Delivery of the engagement Framework will support a consistent approach. Maintain the Communications and Engagement Network and create a range of communications media to our local population and workforce</td>
</tr>
<tr>
<td>Delivery of enabling work programmes to support change i.e. IT and estates and shared care record leading to delay in implementing change</td>
<td>Map interdependencies across work streams and produce regular enabler outputs for work streams and to attend meetings where enabler is highlighted as being a critical dependency</td>
</tr>
<tr>
<td>Financial pressures and individual organisational priorities present a barrier to integrated working and slow progress</td>
<td>Manage improvements within a shared NHS financial control total and leverage flexibility to offset under-performance in one organisation with over-performance in another. Employ shared financial risk management across ICS</td>
</tr>
</tbody>
</table>
Appendix 1: Key Principles

Appendix 2: Link to Final Frimley October STP 2016 submission document

Appendix 3: System Logic Model

Appendix 4: Our CCGs’ and Providers’ Local Priorities for 2019-20

Appendix 5: Our Local Authorities’ Local Priorities for 2019-20
# Appendix 1: Key Principles

**Key Principles that underpin our ICS**

1. Established and driven by data and evidence
2. Supported by new ways of contracting/commissioning – removing traditional boundaries between health and social care, commissioners and providers
3. Driven by strong clinical leadership – including secondary care, GP and community clinicians - across current organisational boundaries
4. Representative of all geographies and stakeholders
5. Integrated and with alignment across the professional disciplines of health and social care to give a care-led approach
6. Operating as one system, one budget with shared resources across health and care in the longer term
7. Financially transparent – CIPs, QIPP and other efficiencies in any sector recognising the impact across the system and clear sight of pressures and flexibilities between parties
8. Holding ownership of risk as a whole system – encouraging system resources to flow to address the greatest risks and provide the biggest impact
9. Sharing benefits – agreeing how system benefits flow to provide the right future investments across the system
10. Based on the principle of subsidiarity, ensuring that decisions are taken as closely as possible to the individual residents and any impact or effect on them
Appendix 2: Frimley STP submission

Link to Sustainability and Transformation Plan October 2016 submission:

https://www.fhft.nhs.uk/media/2388/frimley-stp-oct-submission-for-publication.pdf
Appendix 3: System Logic Model

Sub-outcomes:
- Reduce disease, deprivation & risk factor prevalence
- Early diagnosis & Reduce disease impact
- Reduce dependency
- Personal resilience
- Community resilience
- Limit operational risks / safeguarding issues
- Workforce satisfaction and performance
  - Joined up care
  - Treated at place of choice
  - Tell story once
  - Timely care & assessment
  - Personalised last 1000 days
- Successful clinical intervention
- High quality, suitable people and financially sustainable
- Decrease/shift demand
- Improve efficiency
- Revenue & Investment
- Efficient use of capital
- Right staff in the right place (workforce model)
- Working efficiently
- System collaboration; team working
- Happy, motivated staff
- Staff doing the right thing
- Recruiting high quality staff
- Staff are developed; staff beliefs on own capability
- Retention; Successor planning in place

System outcomes:
- Life expectancy / death rate
- Self reported quality of life
- Taking responsibility for own health
- Operating a safe & secure service
- Positive experience service users*
- Supported carers/family/friends*
- Quality of clinical outcomes following intervention
- Sustainable providers (including General Practice)
- Total system spend**
- Control total
- Estates/Capital value
- Productivity and efficiency
- Attitudes and behaviours
- Capability and skills

System Aims:
- Health & Wellbeing
- Care & Quality
- Finance & Efficiency
- Effective workforce

Appendices
Appendix 4: Our CCGs’ and Providers’ local priorities for 2019-20

**Aim**

Whilst as a system we are working closely together to maximise the impact of our programmes of work, we are committed to addressing local needs and priorities. Our local delivery systems are well placed to effect change and secure clinical and professional, patient and public engagement.

**East Berkshire CCG**

Our local priorities align to national and the Frimley Health and Care ICS strategies and system priorities. Whilst as a system we are working closely together to maximise the impact of our system programmes of work, we are committed to addressing local needs and priorities to effect change and secure clinical and professional, patient and public engagement. East Berkshire CCG’s Strategic Priorities are focused around **Person, Place, Engage and Integrate.**

Our Local Priorities are underpinned by the following key goals; ensuring that our collaboratively developed care models are effective in reducing health inequalities enabling people and communities to be active partners in their health and wellbeing, and supporting the delivery of a financially sustainable health and care system. Local priorities based on the needs of their populations and demonstrate alignment with the CCGs’ Local Priorities and our system priorities. With the exception of Slough, the demographic profiles of the localities are similar and this is reflected in their individual population public health profiles and local Health and Wellbeing Strategies. Each of the Health and Wellbeing Strategies have described their local priorities based on the needs of their populations and demonstrate alignment with the CCGs’ Local Priorities and our system priorities.

In 2019-20 the CCG will focus on the following local priorities:

- **Out of Hospital Urgent Care Programme** – delivery of fully costed options by Q2 2019/202 with Governing Body decision on future model early Q3
- **Local Integrated Care development** – further progression of local integration programmes with partners beyond Integrated Care Decision Making (ICDM) and Better Care Fund (BCF), and including voluntary sector commissioning
- **End of Life Care** – commissioning of out of hours service for CYP, and continuation of transformation of adult end of life care including NHSE supported redesign of fast track CHC, and the continued commissioning of the 24 advice line and rapid response service
- **Children and Young People (CYP)** - delivery of the local CYP transformation plan through increased joint commissioning of CYP services including early help and prevention services
- **Planned Care pathways redesign** – in addition to ICS Reducing Clinical Variation (RV) programme priorities: Ophthalmology, Dermatology, and local Any Qualified Provider (AQP) service or other small contracts which will be ending within the next year
- **Continuing Health Care (CHC) transformation programme** – including formal delegation arrangements with LAs for commissioning of placements, assessment and care management
- **Mental Health services** – delivery of the Primary care focused Wellbeing service, addressing pressures on services not covered by the NHS Five Year Forward View, Personal Health Budgets and mobility services
- **Estates Strategy** - Translation of local transformation programmes into the production of outline and full business cases for ICS capital, and Full Business Case for Primary Care Estates and Technology Transformation Fund (ETTF) schemes
## Our CCGs’ and Providers’ local priorities for 2019-20

### Surrey Heath CCG

The local priorities for Surrey Heath CCG align with the system priorities with a local emphasis on specific areas and focus on business as usual activities such as procurement of local services that fit within the system plan. The aim is to deliver sustainable and consistent care for the needs of the population of Surrey Heath and Ash Vale, that meets the appropriate quality standards within the available funding and as part of the Frimley Health and Care ICS.

In 2019-20 the CCG will engage in the following activities:

**Local Procurements:**
- Continue the procurement for Adult Community Health Services, jointly with NEHF CCG, with a planned contract start date of April 2020
- Take an active role in the Wheelchairs Services procurement for a Surrey-wide service that has a planned contract start date of April 2020 and is being led by Surrey Heartlands STP on our behalf
- Be part of the development and procurement of services for Children and Young People that is being undertaken in Surrey
- Continue engagement in the Integrated Urgent Care co-design project in collaboration with partners across Hampshire that will develop the new NHS 111 and Out Of Hours services along with the updated Directory of Service

**Local Integration:**
- Continue the integrated approach to commissioning with Surrey County Council
- Build on the existing place based relationship with Surrey Heath Borough Council and support them in taking a prominent role in local projects including the Community Asset Based Approach and Social Prescribing
- Support the development and delivery of the “Vision for Surrey” in partnership with Surrey County Council and other stakeholders

### North East Hampshire and Farnham CCG

The local priorities for North East Hampshire and Farnham CCG align with the system priorities with a local emphasis on specific areas and focus on business as usual activities that fit within the system plan. The aim is to deliver sustainable and consistent care for the needs of the population of the CCG. In 2019-20 the CCG will engage in the following activities:

**Local Procurements:**
- Continue the procurement for Adult Community Health Services, jointly with Surrey Heath CCG, with a planned contract start date of April 2020
- Take an active role in the Wheelchairs Services procurement for a Surrey-wide service that has a planned contract start date of April 2020 and is being led by Surrey Heartlands ICS on our behalf
- Be part of the development and procurement of services for Children and Young People that is being undertaken across both Hampshire & Surrey
- Continue engagement in the Integrated Urgent Care co-design project in collaboration with partners across Hampshire, Farnham and Surrey Heath that will develop the new NHS 111 and Out Of Hours services along with the updated Directory of Service
- Review of IAPT (Improving access to Psychological therapies) Services and option appraisal of future contracting options

**Local Priorities:**
- Primary Care Mental Health model development - Building on existing primary care mental health practitioner roles for a truly integrated approach to support physical and mental health, support primary care (including continued offer of GP mental health diploma) and improve care pathways and relationships
- Continuing Health Care – Discharge to assess pathway development with Hampshire and Surrey County Councils in partnership with West Hampshire CCG to allow for whole system working and model funding.
- Home First – Implementation of ‘Home First’ pathways to reduce prolonged stays in hospital, and support timely discharges
Our CCGs’ and Providers’ local priorities for 2019-20

Berkshire Healthcare NHS Foundation Trust

Our vision is to be recognised as the leading community and mental health service provider by our staff, patients and stakeholders. Through our Quality Improvement programme, we have identified our goals to help us achieve our vision, provide outstanding care to patients, and an outstanding place to work:

Harm-free care: To provide safe services, prevent self-harm and harm to others
Supporting our staff: To strengthen our highly skilled and engaged workforce and provide a safe working environment
Good patient experience: To provide good outcomes from treatment and care
Money matters: To deliver services that are efficient and financially sustainable

We have identified 3 supporting strategic initiatives to support delivery of our goals which are:

- Workforce – enabling people to work to the maximum of their qualifications
- Quality Improvement – empowering front line staff
- System work – to improve efficiency and patient outcomes

We also have major investment programmes in information management and technology, and estates. We are a mental health Global Digital Exemplar which entails a significant programme of development across our services and infrastructure. We have significant involvement in ICS priorities, including the ICDM and Connected Care initiatives.

We are focussing our resources in 2019-20 on programmes prioritised through our strategy deployment process. These include:

- Implementing transformational changes to our emotionally unstable personality disorder clinical pathway to better support people in community settings and improve patient outcomes
- Reducing waiting times for children and young people accessing our child and adolescent mental health services
- Improving the environment and patient experience in our assessment and treatment inpatient unit for people who have a learning disability at Prospect Park Hospital in Reading
- Patient safety focus on reducing self-harm, falls, suicides, pressure ulcers, medication errors and gram negative bacteraemia infections
- Recruitment and retention of staff particularly where we have high levels of vacancies such as mental health and community nursing
- Our Quality Improvement Programme will be embedding our Quality Management Improvement System (QMIS) and delivering identified Quality Improvement Projects
- Through our Global Digital Exemplar programme we will be fully implementing e-prescribing and e-observations, expanding online consultations and therapy, and a range of other digital initiatives
- Our Estates strategy with the development of the Whiteknights campus as a hub for integrated children and young people services

We have some key programmes which we are implementing through our system working which are:

- Reducing the number of people who receive mental health inpatient services outside of Berkshire (Out of Area Placements)
- Reducing numbers of suicides (Zero Suicide)
- Providing a more effective response to people who do not need secondary mental health services, with quicker access to talking therapies and signposting to community and voluntary sector organisations (Wellbeing Service)
Our CCGs’ and Providers’ local priorities for 2019-20

Frimley Health NHS Foundation Trust

Frimley Health NHS Foundation Trust (FHFT) will reflect national and ICS strategies and priorities in our local priorities for 2019-20. Our local priorities for 2019-20 will be shaped by our longer-term thinking for the future of the organisation, a key element of which is the development of our 5-10 year organisational strategy, to be completed in Q1 of 2019-20.

Our vision for FHFT will be underpinned by the following six strategic themes:

1. **One Frimley Health**: Tackle unwarranted variation and consistently deliver the best care for patients
2. **A learning organisation**: Ensure we are always improving and putting patients at the centre of our service design
3. **Investing in leaders**: Support our leaders to be the best and enable them to support our great teams
4. **Recognising our people**: Be the best employer, value and empower staff to share and celebrate success
5. **Our #FutureFHFT**: Build on past successes and think ahead to what our services can be in 10 years’ time
6. **Joined up**: Work better with GPs, social care, providers and volunteers to join up care and develop services focussed on wellbeing and less on treating sickness

FHFT will progress these strategic themes to deliver the following local priorities during 2019-20:

- **Deliver and report on key constitutional standards** – such as A&E, Referral to Treatment (RTT) and Cancer. With Cancer in particular we will continue to improve outcomes through the further development of self-managed pathways and delivering an effective recovery package
- **Urgent and emergency care** – the new Urgent and Emergency Care Centre at Wexham Park Hospital will commence a phased opening from February 2019. We will continue to work with system partners to refine patient pathways to ensure that the right patients are accessing the right services
- **Productivity and efficiency** – using benchmarking from ‘Get It Right First Time’ (GIRFT), we will continue to improve our levels of productivity and efficiency whilst offering patients the highest quality services and improving patient outcomes
- **Integration and partnerships** – building partnerships within and beyond the system in order to deliver key services such as community, vascular, renal, OMFS, neurology, stroke, MSK and pain services
- **Moving to financial sustainability** – developing a financial strategy by March 2019, aligned with Trust and ICS strategy, including an integrated CIP and QIPP
- **Digital transformation** – developing our digital strategy in early 2019 and commencing procurement for a new electronic patient record (EPR) and IT infrastructure, which will support the Connected Care programme
- **Workforce** – developing a workforce plan to support our strategic priorities and ensure a sustainable future workforce
Our CCGs’ and Providers’ local priorities for 2019-20

Surrey and Borders Partnership NHS Foundation Trust

The organisational priorities for Surrey and Borders Partnership are aligned with the national priorities within the Mental Health Five Year Forward View and system priorities across the three ICS/Integrated Care Provider (ICP) areas covered by the Trust (Frimley, Surrey Heartlands and Sussex and East Surrey). In 2019-20 the Trust will focus on the following organisational goals:

**Sustainability to maintain**
- Perinatal – funding secured through the Wave 2 bid to be funded in 2019-20 to enable the continuation of new Perinatal service to Surrey
- CORE 24 – funding required to continue CORE 24 compliant Mental Health Liaison services at Royal Surrey County and Ashford & St Peter’s Hospitals
- Austim and Attention Deficit Hyperactivity Disorder services – funding needed to continue increased service in Surrey and Hampshire
- Early Intervention in Psychosis (EIP) – continued expansion of service planned subject to funding
- Long acting anti-psychotics (prescribing) – increased costs for additional prescribing costs associated with move to longer acting anti-psychotics (which improve outcomes and compliance) needs funding

**Working Age Adults transformation**
- Single Point of Access – embedding new ways of working across transformed care pathways following roll out of Single Point of Access
- Primary Care Homes – implementation of new Primary Care Homes model (following evaluation of pilot in 2018-19) in Surrey Heartlands
- Surrey High Intensity – continuation of multi agency partnership approach to working with people with complex needs
- Pathway for people with personality disorders – development of new care pathway and approach to support people with personality disorder to offer a real alternative to hospital admission
- s75 review – work in partnership with Surrey County Council on their review of our s75 agreement and implement recommendations following pilot

**Children and Young People’s services**
- Child and Adolescent Mental Health Services (CAMHS) – continue work to implement post interim plan model to improve access and waiting times
- Developmental Paediatric Partnership (Children and Family Health Surrey, CFHS) - continue to work in partnership with physical health providers and commissioners to improve access and system working for children and young people
- Tier 4 New Care Models CAMHS) – scoping options for the provision of these services

**People with Learning Disabilities**
- Residential social care homes strategy consultation and implementation – consult with people with learning disabilities, their families and carers on their preferred to create more independent living options for their futures

**24/7 Programme**
- Re-development of inpatient facilities to achieve required privacy and dignity improvements for people living in our North West Surrey and East & Mid Surrey communities i.e. those currently using Abraham Cowley Unit, Chertsey
- Digital transformation e.g. TIHM (Technology Integrated Healthcare Management) optimising the learning and outcomes achieved through the research project within our core services and commencing our re-procurement for our Electronic Patient Record (EPR) system in line with its contract
Aim
Whilst as a system we are working closely together to maximise the impact of our programmes of work, we are committed to addressing local needs and priorities. Our local delivery systems are well placed to effect change and secure clinical and professional, patient and public engagement.

Royal Borough of Windsor and Maidenhead

The Royal Borough of Windsor and Maidenhead approved its Council Plan in July 2017. Focused on "building a borough for everyone", the council is working towards six key strategic priorities:

• Healthy, skilled and independent residents
• Safe and vibrant communities
• Growing economy, affordable housing
• Attractive and well-connected borough
• An excellent customer experience
• Well-managed resources delivering value for money

During 2017, the council moved significantly to become a commissioning council – transferring adult services to a local authority trading company, Optalis, jointly owned with Wokingham Borough Council; transferring children's services to a community interest company, Achieving for Children, jointly owned with Richmond and Kingston councils; and outsourcing highways operational services to VolkerHighways and professional services to The Project Centre.

In 2019-20, in delivering its key strategic priorities, the Royal Borough will focus on:

• Implementing new ward boundaries from May 2019, following all out elections on 2 May 2019
• Continuing to embed commissioning arrangements across the council
• Overseeing the significant regeneration of Maidenhead
Our Local Authorities’ local priorities for 2019-20

**Optalis**
Optalis is a Local Authority Trading Company (LATC), launched in June 2011 and wholly-owned by Wokingham Borough Council and the Royal Borough of Windsor and Maidenhead, providing their adult social care services. As a successful LATC and specialist provider, Optalis has a proven track record in delivering excellence across a wide spectrum of services. This is achieved through an approach which blends:

- **Innovation**: doing things differently and doing new things, in response to customer feedback and commissioner requirements
- **Commercial discipline**: ensuring we deliver and can evidence efficiency, effectiveness and value for money
- **A strong value base and public sector ethos**: quality and customer focus at the centre of everything we do
- **Partnership**: working with our commissioning colleagues on the basis of partnership and co-production focused on finding solutions that really work
- **Being a good employer**: making sure our staff are clear about the standards we expect and supporting them to be the best that they can be

In 2019-20 the priorities in Windsor and Maidenhead for Optalis are to:

- Deliver robust hospital to home services for residents across the borough
- Manage demand for adult services through implementation of Each Step Together
- Work with the Royal Borough and partners to deliver the outcomes of the Local Government Association (LGA) DTtoC peer review
- Continue to maintain excellent performance on social care attributable DToCs
- Deliver an East Berkshire wide care governance model primarily for the East Berkshire approach to CHC services/placements and for placements and placements/services in general

**Achieving for Children**
Achieving for Children is a community interest company, launched in 2014 and wholly-owned by London Borough of Richmond, Royal Borough of Kingston upon Thames and the Royal Borough of Windsor and Maidenhead, providing all their children's services, across education, early help and social care.

We strive to achieve excellence in everything we do by putting children and young people first in the design, delivery and evaluation of every service we provide, to ensure that they are supported to live safe, happy, healthy and successful lives. Our broad service offer is informed by leading practice and a strong evidence-base of what works best. It is guided by our daily work with children and young people and the organisations that work with us to help and support them.

Our focus is always on maximising the use of resources by creating economies of scale and reducing management and overhead costs, so that we can ensure high quality frontline services that really deliver results. We continually seek to strengthen our offer by learning from innovation and by investing in the skills and professional abilities of our workforce.

In 2019-20 the priorities in Windsor and Maidenhead for Achieving for Children are to:

- Deliver new safeguarding arrangements which replace the Local Safeguarding Children Board
- Manage demand for children’s services through the MASH and robust assessment
- Work with CCG and provider partners to deliver the Local Transformation Plan, including joint commissioning
- Continue to deliver the SEND action plan, in partnership with health and schools
- Work with ICS partners to deliver the children's plan
Our Local Authorities’ local priorities for 2019-20

Slough Borough Council

The priority outcomes for Slough Borough Council – Putting People First:

- Slough children will grow up to be happy, healthy and successful
- Our people will be healthier and manage their own care needs
- Slough will be an attractive place where people choose to live, work and stay
- Our residents will live in good quality homes
- Slough will attract, retain and grow businesses and investment to provide opportunities for our residents

This is supported by a transformation programme with a focus on:

- Delivering a new customer strategy and approach to working with residents and a new customer insight function
- Our staff working better to meet customers needs
- A new accommodation and hub strategy – including moving to a new town centre headquarters
- A new digital strategy with a digital by default approach
**Our Local Authorities’ local priorities for 2019-20**

**Surrey County Council**

Over the spring and summer of 2018, Surrey County Council engaged with residents, communities and partners across the county to understand what Surrey should look like by 2030. Informed by the conversations we had, we have been able to create a shared vision for Surrey. The council cannot deliver the Vision for Surrey alone, we will need the support and involvement of partners and residents.

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**SCC Community Vision**

By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind.

Our ambitions for people are:

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

We want our county’s economy to be strong, vibrant and successful and Surrey to be a great place to live, work and learn. A place that capitalises on its location and natural assets, and where communities feel supported and people are able to support each other.

Our ambitions for our place are:

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

We are now working to transform our services so they can be in the best place to deliver our 2030 ambitions. We have to achieve your Vision against an ever increasing demand for services and decreasing budgets. We therefore need to look at how we deliver services, considering new ways to help our residents that need us most. We also need to look at how we, as a council, operate, ensuring that our residents are receiving the best from us and ensuring we are as efficient and effective as we should be.

- **Organisational Strategy (PDF):** We have developed a new Organisational Strategy that looks at how we will work over the next four years and enable us to deliver the Vision and make a real difference to residents’ lives
- **People Strategy (PDF):** To enable us to deliver for Surrey Residents, we need to ensure we have the right workforce with the right skills. Our People Strategy sets out how we will develop the capacity and capability of our workforce to achieve the changes we need
- **Prelim Financial Strategy (PDF):** We need to ensure the council has a balanced budget. As funding decreases and demand for services increases we need to ensure we are in a position to continue to provide services. Our Prelim Financial Strategy sets out how we will achieved a balanced budget
Our Local Authorities’ local priorities for 2019-20

Surrey County Council

• Business Cases (PDF): We have developed a number of business cases that underpin how we will change as a council and therefore enable us to deliver effective services to residents and achieve our Community Vision for Surrey 2030

Our priorities in 2019-20 within the business cases include:

• Continuing to develop new models of care across health and social care teams working collaboratively with partners
• Improved provision of adult care services (ACS)
• Develop a new strategic commissioning approach based on understanding of need
• Continue to deliver SEND actions to improve our outcomes
• Develop a revised service and operating model for children’s services
• Develop stronger data and insight capabilities, and leading edge performance management and insights
• Deliver improved customer experience with a single front door for customers
• Continue to develop our agile workforce
• Develop our Place Strategy and Implementation Plan
• Develop enhanced range and capacity of options of accommodation with care and support